

OBESITY AS A CAREER

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INTRODUCTION

Guiding Perspectives

Obesity has become one of the leading health problems in the United States. Concern with body proportion leans toward being a national preoccupation as one cannot experience various communication media without receiving a barrage of propaganda and facts, both commercial and medical, regarding obesity and overweight. The concepts of youth, health, health foods, and their relation to exercise and occupation are pervasive throughout today's society. The war against fatness is supported by a ten billion dollar diet industry that includes 14.9 million dollars a year for Weight Watchers, 220 million dollars for reducing spas, 100 million dollars for exercise equipment, 54 million dollars for legal diet pills, and millions more for diet foods and diet books (The San Francisco Chronicle, 1973). Slimness and liteness suggest youth and agility with prospects for a longer, more productive life. "The old view of medicine - that patients are sick because of their sins, including their lack of self-restraint - a view which has been generally abandoned in the Western world even in the matter of alcoholism - still dominates as far as obesity is concerned" (Mayer, 1968, p.1).

What happens to the forty to eighty million Americans, according to the United States Public Health Service, who are currently caught in the universe of exercise and dieting because they fit somewhere on the continuum between slightly overweight and obesity? What is it to live with obesity, to experience life through this added dimension? Health related literature is saturated with a clinical orientation toward obesity, i.e., adipose tissue metabolism and obesity, obesity - its causes and symptoms, psychological studies of the obese and their families, etc. The literature reveals little, however, about obesity from an obese individual's perspective: his strategies for coping with weight and/or controlling it, or the ways in which corpulence affects his everyday life in twentieth century America.

Problem Statement

The focus of this research is 1) to identify realities of obesity from the perspective of the obese client and 2) to describe how self-identified obesity determines, modifies, or impedes normal human processes such as dressing, managing everyday problems, moving about, working, and caring for health needs. This dissertation does not directly con-

cern itself with psychopathological correlates of obesity, whether etiological or consequential, nor is it concerned with the physiological aspects or course of obesity.

In order to pursue the above mentioned research objectives, a 1:1 relationship with the obese clients was necessary. Field research methods offered the best avenue for capturing the universe of obese individuals within their natural environment and for answering the following research questions:

- 1) What are the realities or understandings of obesity from the client's perspective?
- 2) In what manner does self-identified obesity determine, modify, or impede normal human processes such as dressing, managing day-to-day problems, moving about, working, and caring for health needs?

One of the goals for nursing and other health professions is increasing the understanding of a complex condition: obesity. Increased understanding of corpulence, particularly from the stance of the obese individual, can lead to more diversified and comprehensive health care plans which might be activated without unnecessarily inducing psychosocial strains detrimental to health, in the name of health.

Prior to moving into descriptions of the theoretical framework or data analysis, a journey into the world of the obese will introduce the

reader to individuals who occupy this world. One can follow obesity as it evolves through man's history and view obesity as it is related to contemporary health ideologies. Lastly, the reader can grasp the perspective of the researcher in generating a theory of obesity as grounded in the research data and view the implications of this theory for health care delivery to the obese.

PART I - THE APPETIZER

CHAPTER I - EXPERIENCES IN LIVING WITH OBESITY

I've lost at least a thousand pounds.
A feat you claim, that quite astounds?
But no - it's just the same old ten,
Over and over, again and again.

Dalene Workman Stull

An important research principle related to symbolic interactionism suggests the investigator take the perspective or "role of the acting other" and view the world from his subject's point of view (Manis and Meltzer, 1972). The approach of viewing the world from his subject's point of view enables the researcher to capture the definitions and meanings used by respondents in order to better understand their behavior. "Taking the role of the acting other permits one to escape the fallacy of objectivism; that is the substitution of his own perspective for those he is studying" (Manis and Meltzer, 1972, p.80). Too often field researchers enter the field with preconceptions that prevent them from allowing respondents to tell it "as it is". As one of the objectives of this research is to determine the realities of obesity from the obese

client's perspective, upholding this key element of symbolic interactionism is crucial.

To learn about obesity from the affected client's perspective, 1-1 1/2 hour interviews were conducted with twenty obese individuals. The twenty respondents were individuals who had been diagnosed as obese by a physician and who were at least twenty-three pounds above normal body weight for height, bone structure and sex (Shumway and Powers, 1973). The respondents came from a variety of settings where obese individuals were easily found: comprehensive medical clinics, health spas, obesity clinics, and private physicians.

Two clients from the sample were selected for the following vignettes so that the reader might vicariously take the role of the obese individual and grasp the concept of living with obesity. The first client, Mrs. B., a thirty nine year old Caucasian woman weighing 214 pounds, began her experience with obesity after the birth of her last child at thirty-two years of age. "Obesity is more mental than physical", related Mrs. B. "I'm just a food-a-holic and eat when I'm nervous." Mrs. B. described how she ate "like a vulture" during the day while at home alone. However, when people were around she ate "like a canary", and no one could understand why she was so fat.

According to Mrs. B., her life was hectic and full before she became obese. She had worked as a secretary and kept her weight to ap-

proximately 130 pounds for her height of five feet three inches. Mrs. B. and her husband once had an active social life and often entertained a number of friends in their home. During her early thirties, Mrs. B.'s children were young and had kept her busy and feeling useful.

Mrs. B. felt that with her weight gain she had "escaped into fifty layers of fat". She was ashamed for anyone to see her and had greatly reduced her social contacts. Her shame and fear that no one would hire her because of her weight prevented Mrs. B. from seeking a job even though she expressed a desire to work. A further problem area was her relationship with her husband. Mrs. B. felt that her husband did not wish to be seen with her socially, and thus most of their time was spent at home. However, even when her husband asked her to go out, Mrs. B. often found an excuse not to go because of embarrassment about her weight.

Mrs. B. began dieting when she was thirty-five years of age. She had seen a physician for her annual check-up who told her that she needed to reduce. At that time this client was given a low-caloried diet and some appetite suppressants. Yet, during a family celebration shortly after this annual check-up, she ate and drank so much that she suffered from a severe attack of indigestion and thought she had a heart attack. Subsequently, Mrs. B. returned to her physician who again insisted that she must lose weight.

This client reported that she had trouble staying on her diet because food was a means for relieving her stress. "All obese people know about calories, but they also need to talk about problems that make them eat and what it is like to always diet", stated Mrs. B. Walking often proved tiring to her, and she frequently got indigestion from eating too much. Her large size also prevented her from getting clothes that she wanted, yet Mrs. B. stated that she lacked the self-discipline to do what was good for her.

Mrs. B. had recently visited her physician and was told that she was not trying to lose weight. "I asked the doctor to give me another chance, but maybe I'm just going to have to live with fat since twenty pounds is the most I've ever lost," Mrs. B. declared.

To illustrate another account of living with obesity the story of Miss M. has been selected. This twenty seven year old young woman is single and employed as a teacher. "I was never a fat child, but have always been pudgy," she declared. Miss M.'s weight had "see-sawed" up and down all of her life, but her experience with dieting began in high school. She began trying to reduce after deciding that her body was poorly proportioned evidencing large hips, thighs, and arms.

Miss M. related that she always felt as if she should be trying to lose weight and learn to delay satisfaction. "I struggle all the time because I really like food. I feel hungry a lot and feel as if I'm

always monitoring what I should or should not have. Constant restriction is my motto", she declared. Miss M. had attempted a variety of weight reduction methods: fad diets, weight reducing clubs, and physicians to obtain diets and appetite suppressants. According to Miss M., people had accused her of having no willpower by saying, "You could lose weight if you wanted; nobody has to be fat." "Obesity is possibly the only thing in my life that I've never been able to control to any degree of satisfaction", she explained. Miss M. had put forth efforts at dieting but never felt that she made much progress.

Miss M. saw herself as being very big, a thought probably somewhat out of proportion to her actual body size. She felt that the increase in her weight to 169 pounds for her height of five feet six inches had affected her dating in the last five years. Before this time, Miss M. had been school-oriented and studying had been a high priority. "I think you can reach a point in your body size, and I see myself as there now, when I say to myself that I can't expect people to be interested in me when I'm not doing the most to lose this weight. I think people are intolerant of obesity", she related. Miss M. viewed obesity as a negative attribute. She disliked herself for being overweight and spent time hoping that other people would not dislike her for the same reason.

This young woman felt her social life to be hampered by her obesity. Her weight prevented her from swimming in public swimming pools or sun-

bathing on public beaches. "I would never lie on the beach and show off my rolls and tapioca thighs", she exclaimed. Miss M. related that her dating had been reduced, and she was surprised when she met people who wanted to take her out as she did not feel herself to be attractive. At the time of the interview, this client was involved with a young man and hoped that her increased weight would not jeopardize this relationship.

In discussing other effects of obesity on her life, Miss M. declared that the greatest problem for her was the mental and physical strain of trying to lose weight. "I expend a lot of energy trying to force myself to exercise when I'm tired and trying not to think about being hungry." This interviewee wanted to lose thirty to forty pounds in order to look good in clothes and be able to wear the types of clothes she desired. To be fat was physically and mentally uncomfortable for this young woman. Losing weight would also give her more energy, and her back would not hurt as much from walking. "I have a constant battle with myself," she declared. "When losing weight and feeling better, I ask myself why this isn't enough to keep me stimulated and reducing. And then I ask myself, is all this worth it?" Miss M. continued to explain that she would get tired and discouraged and question the worth of trying to lose weight. She questioned the value of diet and exercise, because she was always hungry and felt tremulous after exercises.

Miss M. saw obesity as a weakness that can not be hidden from other people and feared the restrictions of dieting to be a life long process for her. She did not view her eating and exercise patterns as so different from those of other people and questioned why she gained weight and others did not. Miss M. felt that the most significant problem of being obese was having weight on one's mind constantly. "Worry about how you look, and how you appear to others and when and what to eat, are a constant strain", she said.

This young woman's goal was to wear a size twelve dress. She was going to a doctor, taking appetite suppressants, and developing an exercise regime to attain this goal. According to Miss M., "There is nothing but my own hard work that I can trade to get this size twelve image".

These interviews are typical of the sample and represent many of the characteristics of the total research data obtained. Difficulty purchasing clothes, decreased social life, and struggles with weight reduction regimes are common themes that have been identified by the researcher in attempting to take the role of the obese individual and by doing so exemplify an important component of symbolic interactionism.

CHAPTER II - FROM FATTENING HUT TO STEAM BATH -
AN EVOLUTION OF CONCEPTIONS AND PRACTICES RELATED TO OBESITY

Early Historical Accounts of Obesity

Social customs and economic conditions have dictated the prevalence of obesity throughout history. For example, obesity waned during the Old Testament period when the Bible forbade the eating of animal fat and returned during the "golden days" of the Roman Empire. Often called "the thorn of plenty", fatness has fluctuated according to a society's degree of richness or poverty (Wyden, 1965). Obesity is proclaimed as a problem of an affluent society and is said to occur only in those geographical areas where an abundance of food is available to the masses of people. During economic catastrophes, famines, and wars, when the quantity of food is often greatly reduced, obesity and its related problems disappear (Gordon, Goldberg, Chosy, 1963).

In viewing obesity from some of the earliest historical accounts, it is interesting to note that the oldest representation of human form, dating 20,000 to 30,000 B.C., was the "Venus of Willendorf", a statue of an obese woman with enormous breasts and abdomen (Wyden, 1965). Other artistic works of the prehistoric Greek and Egyptian periods indicated a preference or artistic admiration for women with large, protruding abdomens, heavy hips, and thighs. Bruch explains that no one can be certain if these "goddesses" were realistic representations of women of that era or if they were the artists' symbolized dreams of abundance and fertility amidst the ever present threat of famine. Man's fear of starvation has continually affected his actions, and his history has often been called "the chronicle of man's quest for food" (Bruch, 1973, p.9).

Effects of Fashion Industry on Body Style

Man is the only living creature who possesses the urge to alter his body. "No shoe is too bone-breaking, no corset too breath taking, no bodily alteration too excruciating for man not to have attempted in his continuing pursuit of the 'Fashionable Body'" (Rudofsky, 1971, pp.57-58).

Body altering practices took the form of molding and changing the shape of the head and feet in some of the earlier societies, but obesity has been the most enduring of all the body altering processes (Rudofsky, 1971).

In the Western world of the mid 1800's, the desirable figure moved from that of the rotund, voluptuous woman to that of a woman who was stout and buxom with a tiny waist. Since this combination of body proportions was not commonly a gift from nature, the corset was invented to mold one's body into this desired shape (Rudofsky, 1971). Most historical accounts reviewed discussed body form, attractiveness, and fashion in relation to women. Little reference was made to men and society's views of men's shapes and acceptability.

By wearing the corset, the woman of the nineteenth century may have increased her seductiveness; however, this garment often harmed the internal organs of its wearer. Yet, physicians who saw the physical damage done by these corsets hesitated to interfere with fashion's dictum for fear of being labeled immoral. According to Rudofsky, the corset had become a hallmark of virtue as men believed that a large purpose in the design of clothes was to punish the flesh. Man was still doing penance for the sin in the Garden of Eden, and clothes were instruments of moral philosophy. The unlaced waist was a vessel of sin, and some men felt that women's gradual liberation from corset and garter was another symptom of the immorality of the age (Rudofsky, 1971).

Feldkamp reports that in the early 1900's women were liberated from the corset by a man named Paul Poiret, a king of fashion. His style sought freedom and naturalness, and his clothes followed the contours of the body. This radical change in fashion encouraged women to become more conscious of their bodies and calorie counting. No longer could women conceal their fat under ballooning petticoats and leg-of-mutton sleeves (Feldkamp, 1972). The rejection of the corset did not lead to the rejection of the dream of the "fashionable body", as the motto became - "waist not, want not: Space Age slimming" (Rudofsky, 1971, p. 64).

Some physicians saw fashion trends as harmful to weight reduction. For example, when fashion dictated the need for large bustlines, women, in an effort to achieve this image, often deposited fat over their entire bodies. Any weight reduction would cause a woman to sacrifice what the world considered beautiful. This situation evidenced the conflict between health and society's dictum for beauty (Bruch, 1973, citing Les Grandes et Petites Obesites, 1911).

Changing Attitudes Toward Obesity

In the days of the early Greeks, Romans, and Spartans, obesity was disliked. For example, each month the people of Sparta were stripped and inspected for signs of fatness, and in the event that increased weight was found, the individual was ordered to begin an exercise program. The Romans were known for their vomitoriums and adhered to the practice of eating as much as they desired, and then vomiting (Bruch, 1957).

Among some of the primitive tribal societies, obesity was viewed as a positive attribute. A great deal of the work and community activity was centered on the production and acquiring of food through farming, hunting, fishing, etc. Therefore, in a number of tribes, gaining weight meant achieving the high distinction of becoming so well nourished that one became fat (Cloete, 1953). Obesity was a mark of success and honor. Royal wives led lives of leisure and were carried about on litters, sparing any unnecessary exercise. In some African societies, young maidens were sent to fattening huts to prepare themselves for marriage. Social custom dictated that the fatter the girl, the greater her beauty, but the young men had to remain slim and athletic. The fattening of these young girls supposedly had not only an esthetic purpose but also the purpose of readying the maiden for the demands of adult life such as pregnancy (Powdermaker,

1960). Other primitive tribes discriminated in their admiration for obesity between an overall bulky appearance and strategically placed fat. For example, women with fat hips, buttocks, and thighs were thought to possess greater beauty than those with overall body fatness (Rudofsky, 1971).

The Middle Ages brought various views on obesity. Some saw corpulence as the "Grace of God", and others viewed it as gluttony, a sin closely related to pride and lust. For example, in Lochner's painting of "The Last Judgement", the sinners depicted as going to Hell were fat, while the fortunate ones going to Paradise were slim (Bruch, 1973).

The Western world and the United States also experienced marked fluctuations in attitudes regarding obesity. In the late 1800's, for instance, fat was a sign of success as represented by the corpulent millionaires like Diamond Jim. Also, among lower and middle class immigrant families of the 1930's, food represented success and freedom from want. Many of these people had experienced hunger in the "Old Country", and thus encouraged their children to eat. Being "hefty" was a positive attribute. Food also represented love among many of these immigrant families, and it was considered an insult to enter a home without eating heartily (Bruch, 1973).

A survey of 1600 adults living in New York City in the 1950's revealed that obesity occurred seven times more frequently among women of the lowest socioeconomic level than among those of the highest level. Among

men the same relationship existed, but to a lesser degree. This report also revealed that lower class people expressed little concern over being overweight (Moore, Stunkard, and Srole, 1962). This lack of concern over being overweight may be attributed to experiences with deprivation which may have led members of lower socioeconomic groups to connect obesity with well being and prosperity (Goldblatt, Moore, and Stunkard, 1968). Dr. Hilda Bruch suggests that lower income groups may be less complacent about their weight today as the influence of television has flashed the ideal body image of the slim, youthful figure into the homes of millions of people, rich and poor alike (Bruch, 1973).

The decade of the Sixties brought further emphasis on the young skinny figure through the example of Twiggy. Society looked unkindly on the obese individual with fatness connoting "weakness, laziness, and lack of self-discipline" (Craft, 1972, p.679). For example, studies by Dr. Jean Mayer revealed that colleges discriminate against the obese individual. An obese person has only one-third as much chance to be admitted into a "prestige" college, the college of their choice, or indeed any college, as a non-obese individual (Mayer, 1968). Also, according to Maddox, many Americans regard obesity as a socially deviant form of physical disability. The obese are blamed for being fat, but people with other physical disabilities are blameless, as they are not responsible for their condition. Some members of society view obesity as immoral,

arising from sins of gluttony and sloth (Maddox, 1968).

During the decade of the Seventies, minorities are fighting for their rights, and women are seeking equality and advancement. Symbols of the age are individualism and the freedom "to be". Fat people are also organizing and struggling against the old societal restraints regarding beauty and the "fashionable body". One organization, the National Association to Aid Fat Americans, Inc., has been formed to fight against the stigmatizing of obese people. According to this group, fat people face discrimination by religions, physicians, the life insurance industry and colleges. A main goal of the N.A.F.A. is "to open people's eyes to the legitimacy of multiple body styles" (San Francisco Chronicle, 1973).

The 1970's style of living with its abundance of food and its increase in modern conveniences to reduce man's energy expenditure further perpetuates problems with gaining weight for many people. Modern man has demanded and constructed a society that has made it hard to stay thin (Spark, 1974). Thus, to counteract increases in body size, dieting groups and exercise salons have been created. In today's affluent society, fatness is within the reach of many individuals. The future will reveal whether the "counter cultures" of fat individuals like the National Association to Aid Fat Americans will succeed in increasing society's acceptance of a multiplicity of body styles and sizes. Will the future of mankind lead to the "fattening huts", or to the "steam baths"?

CHAPTER III

OBESITY AND HEALTH - CONTEMPORARY HEALTH IDEOLOGIES

The picture of obesity would not be complete if its health related and environmental components were not discussed. Physiologists, endocrinologists, psychologists, and a variety of other scientific specialists have been researching the complex physiological and psychological aspects of obesity for a number of years. Key points to keep in mind when thinking of corpulence and its relationship to the functioning of the human body are : 1) What causes some individuals to become fat? and 2) Do alterations in metabolism and hormones cause obesity or do these changes occur as a result of obesity? To explore these two areas as well as others of this nature, this chapter will present physiological, psychological, and anthropological facets of obesity as well as current treatment strategies, utilizing a health orientation and the works of leading authorities on obesity. Due to growing public interest, obesity has also become a popular topic for the mass media, i.e., television, magazines, etc. Therefore, some references will be used from this source with

scientific data to lend support.

Obesity As Defined by Health Authorities

The fact that the number of Americans who are overweight has reached "epidemic" proportions in some segments of the American population (Dwyer, Feldman and Mayer, 1970), and the fact that six million Americans are "morbidly" obese gives credence to the need for greater understanding of this condition - obesity (Phillips, 1973). For clarity, the words overweight and obesity must be differentiated. Overweight pertains to body heaviness in excess of ideal weight based on specific standards for height and sex. Increases in weight may result from bone and muscle as with football players who may be overweight because of muscle and bone structure, yet not be overfat (Dwyer, Feldman, Mayer, 1970). The term overweight is also seen as being ten per cent above optimal weight for height and sex standards. (Craft, 1972). However, if an individual is twenty per cent or more over the standard weight for his height and sex, he is considered clinically obese or his body is excessively fat (Dwyer, Feldman, Mayer, 1970).

Craft defines obesity as "that bodily state in which there is an excessive accumulation of fat in both the relative and absolute sense; that is, the per cent of body weight present as fat is greater than normal, and the total body weight is abnormally high" (Craft, 1972, p.678). Dr. Albert Stunkard views obesity as a chronic condition for which we have no cure. This condition is resistant to treatment and prone to relapse (Phillips, 1973). Another authority defines obesity as a symptom of underlying pathological processes which occur as a result of biological, social, psychological, and acquired metabolic factors (Crisp et al, 1970).

Drs. Jean Mayer and Richard Stuart agree that in theory the question as to the definition of obesity is easily answered. However, in practice defining obesity is not simple. For example, commonly used tools to measure obesity are the height and weight tables prepared by insurance companies. Dr. Stuart criticizes these tables because the early standards developed were based on heights and weight of men and women of various ages who were not representative of the general population, as all were policy holders, and thus belonged to the middle or upper socio-economic strata. A second criticism was the fact that these widely used tables indicated that weight increased with age which unintentionally implied that maturity onset obesity was acceptable. Therefore, the height and weight tables were revised by insurance companies to replace age distribution with desirable weights for men and women of differing heights and frame size but still retained a sample composed of policyholders

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(Stuart and Davis, 1972). Even with the revisions, the height and weight tables did not provide adequate criteria for determining differences between small, medium, and large frames and conditions of weighing were not standardized. Therefore, nude weights were estimated to be five to eight pounds less than tabular weights (Stuart and Davis, 1972).

Among other methods for assessing fatness are such unscientific means as the following described by Dr. Jean Mayer:

1. The Mirror Test - looking at oneself nude in a mirror. If one looks fat, then he probably is fat.
2. The Pinch Test - a skinfold greater than one inch on certain body locations such as back of the arm, side of the lower chest, the abdomen, the back of the calf indicates excessive body fatness.
3. The Ruler Test - with a person lying on his back, a ruler is placed on the abdomen along the midline of the body. This ruler should touch both the ribs and the pelvic area. If it does not touch both areas, the individual is too fat.
(Mayer, 1968, p. 29)

Dr. Mayer thinks that a better means of assessing obesity is through the use of "Anthropometric measurements of skinfold thicknesses; circumferences and diameters of chest, trunk, abdomen, and limbs in various places; and (by means of soft tissue x-ray) widths of skin plus subcutaneous tissue, muscle layer in limbs, and of bones" (Mayer, 1968, p. 31). The National Health Survey of the United States Public Health Service has also included skinfold measurements as one of its assessment tools for obesity. The skinfold measurements are a

scientific refinement of the pinch test mentioned earlier and are measured with external calipers. The skinfold measurement to be obtained is the thickness of the pinched skin and attached subcutaneous adipose tissue. The triceps area is most commonly used as it is considered most representative of total body fatness (Mayer, 1968).

Extensive data on skinfold values have led Drs. Seltzer and Mayer to determine normal variations of skinfold measurements for the Caucasian population of the United States. The relation of skinfold thickness to body fat content is independent of height, thus, the measurement of skinfold density greater than one standard deviation above the mean indicates presence of obesity (Seltzer and Mayer, 1965).

It is evident that various means for determining obesity exist. However, procedures used and results obtained may not always be consistent. Therefore, the United States Public Health Service has warned that "assigning a label of obese to anyone should come only after a comprehensive assessment of all pertinent factors" (Stuart and Davis, 1972, p. 8). Factors to be considered in determining obesity include the person's age, body type, state of health, and skinfold measurement. Comparing any individual only in terms of his height and weight with a given set of standards does not give adequate data on which to assess obesity since such comparisons imply weight and not fatness (Stuart and Davis, 1972).

Genetic Factors in Obesity

Theories pertaining to the causes of obesity are abundant and varied. One such theory relates genetic factors to obesity. Through his work with mice, Dr. Jean Mayer has shown that genetic factors do influence the development of obesity in animals. The need to manipulate breeding patterns for such research has prevented this work from being done with humans. However, Dr. Mayer's assumption is that obesity in humans may also follow genetic transmission. These genetic traits may not determine obesity itself, but rather the potentialities for overeating and/or underexercising and obesity (Mayer, 1968).

Some authorities think fatness is predictable. For example, a study conducted in Boston indicated that nine per cent of children of normal weight parents were obese while obesity was found in forty to eighty per cent of children of one and two obese parents respectively. These percentage differences were felt to indicate a hereditary connection as adopted children showed almost no correlation with the weights of their parents (Johnson, Burke, and Mayer, 1956).

Dr. Hilde Bruch sees obesity as being influenced by both genetic and environmental factors. She states that "genetic potential is determined at the moment of conception, but the extent to which the potential develops is dependent upon the organism's interaction with the environment" (Bruch, 1973, p. 27). The question Bruch raises is how much of

obesity is biologically given, how much results from environmental experience, and how do these two components interact? Dr. Bruch's intensive work with a group of obese women influenced their rearing of non-obese children and their providing these offspring with a free choice of what and how much to eat (Bruch, 1973). Dr. Bruch has also manipulated the environment of animals not genetically predisposed to obesity to illustrate how environmental influences may create corpulence, excessive fatness. Her experiments indicated that a normal mouse sharing a cage with an obese mouse will gain more weight than litter mates not associated with the fat mouse. Infant baboons who were provided with a self-feeding device for their formula diet and given continuous access to food, outgained the infant baboons who had nourishment offered periodically (Bruch, 1973).

It is evident from the studies of these recognized authorities that the question as to which bears greater influence on obesity, environment or heredity, remains unanswered. While genes may predispose one to obesity, the overeating and/or under-exercising leading to a positive energy balance still must occur for obesity to develop. According to Dr. Jean Mayer, a prevailing acceptance of the involvement of genetic factors in the development of obesity would provide a more solid basis for instigating preventive treatment. For example, if it is recognized that children with one obese parent are likely to become obese and children with two obese parents will probably become

obese, then improved food habits and exercise patterns may be developed early enough to prevent obesity from occurring (Mayer, 1968). According to Dr. Hilde Bruch, the problem of obesity has not been clarified by the traditional means of asking which is the causative agent in obesity - heredity or environment? Perhaps the focus should move toward accepting these two components and viewing them not in opposition to each other, but in terms of their interdependency in the development of obesity (Bruch, 1973).

Socio-Cultural Factors Relating To Obesity

Obesity is likely to develop during certain periods in the life cycle: infancy, school entrance, puberty, and pregnancy (Wilson (ed.), 1969). The prevalence of obesity varies with age, sex, socio-economic status and possibly ethnic variables (Dwyer, Feldman, and Mayer, 1970). For example, weight increases with age at a rate of one pound a year after the age of twenty-five (Spark, 1974). Men, however, gain more weight in their early twenties, and women achieve their maximum weight gain during their forties, having a greater relative weight gain with

age than men. This variation in number may be due to obese men dying in proportionally greater numbers than non-obese men or obese women (Dwyer, Feldman, and Mayer, 1970). Excessive weight deviations are more severe among the adult population, yet adults are less concerned and less likely to begin reducing measures than teenagers. If adults take any action, it is usually in the form of eliminating "fattening foods" to prevent any further weight gain rather than attempting to remove present excess weight (Wyden, 1965).

Dwyer and Mayer found that adult women of the upper class are more concerned about weight than men in this socio-economic bracket. Dieting is also more prevalent among females than males in the upper socio-economic class (Dwyer and Mayer, 1970). This greater concern about weight among women than men may be partially due to the social liability of obesity for women. Successful men may be overweight, but obese women rarely have a successful career nor are they wives of famous men. Weight related aspects of appearance are more intertwined with self-concept in women than in men, and women realize the importance of physical appearance in attracting the opposite sex (Dwyer, Feldman, and Mayer, 1970).

Moore, Stunkard, and Srole studied the relationship of obesity and socio-economic status. This study revealed the percentage of obese women is thirty per cent in the lower socio-economic bracket, sixteen percent in the middle economic strata, and five per cent in the upper

income level. Correlation between height and weight standards and socio-economic status was particularly high in women as obesity was found to be seven times higher among women of the lowest economic strata as compared with those of the highest economic status (Moore, Stunkard, Srole, 1962). For obese men, the differential between social classes was not so pronounced. The difference in incidences of corpulence between upper and lower classes was only a factor of two as against a factor of seven for women (Geigy Report, 1973).

Membership in social and cultural groups may cause people to vary in the degree of importance they place on their body size or weight. One reason for the variation in opinions about body fatness may be that individuals of a socio-cultural group differ in the amount of exposure they have to health professionals and other sources who might make them perceive themselves as fat (Dwyer, Feldman, and Mayer, 1970). Goldblatt, Moore and Stunkard discovered that some members of lower socio-economic groups may not regard obesity as culturally undesirable as do those of higher social status, because their experience with deprivation may have led them to connect obesity with well being and prosperity. People of social class vary in behavior toward many problems, particularly health, so they could not be expected to be homogenous in their behavior towards obesity. However, there is more similarity among the social classes involving concern about weight and dieting than occurs

with other issues. Perhaps this similarity of opinion is influenced by the presence of an obese individual in every social class and mass media and schools foster homogenous ideas toward obesity (Goldblatt, Moore, and Stunkard, 1965).

A question one might raise is which came first, the social status or obesity. Dr. Gene Weltfish, a noted Anthropologist, proposes that obesity can be the result of poverty, as people cannot afford many protein foods and subsequently resort to eating a number of starches and sweets (Ramsey, 1973). Research has also shown that obese individuals are discriminated against educationally and occupationally, thus their position on the social scale might be lowered (Thomas and Mayer, 1973; Mayer, 1968; Geigy Report, 1973). However, Dr. Albert Stunkard studied the socioeconomic status of parents of obese women but could detect no specific social effect of obesity from his data (Geigy Report, 1973).

In terms of ethnic differences in the occurrence of obesity, Hathaway and Foard suggest that obesity is more prevalent among Black women than Caucasian women. However, "racial differences are usually confounded with socioeconomic class, so it is difficult to say whether racial differences exist if class is held constant" (Dwyer, Feldman, and Mayer, 1970, p. 270).

Metabolic Factors Relating To Obesity

Based on the original study by Sheldon, Drs. Seltzer and Mayer found that one's somatotype has influence on the development of obesity. The three body types found in man are the endomorph who has a large, soft, round body and short arms and legs; the mesomorph who has a muscular body with prominent joints; and the ectomorph who has slender, small body with long arms and legs (Mayer, 1968). In their study of obese adolescent girls, Seltzer and Mayer found the obese girls to have somatotypes of endomorph and mesomorph. Their conclusion was that a prime prerequisite for obesity is a somatotype that contains a moderate amount of endomorphy, which predisposes to the distribution of additional quantities of fat unless diet monitoring and increased activity supervene (Seltzer, 1972). Dr. Jules Hirsch found that an increased number of fat cells results from eating habits of childhood and adolescence. Once these fat cells are developed, there is no way of eliminating them (Hirsch, Knittle and Salans, 1966). When weight loss occurs, fat cells decrease in size, but the number remains the same. Therefore, a prime way to curtail the prevalence of obesity is to alter the eating patterns of children (Bray, 1970).

The question still prevails as to why do people get fat? The centers for hunger and satiety are professed to be located in the

hypothalamic area of the brain. A derangement in the normal mechanism involving sensations of hunger and satiety may lead to overeating (Young, et al, 1971). After periods of food deprivation, alterations in the body's blood chemistry activate the hunger center in the hypothalamus which sends out signals for the body to seek food. The stomach contracts more frequently, the individual eats, changes occur in the blood chemistry, and the satiety center is activated. Thus, the hunger center rests, the stomach ceases its contractions, and the individual feels full. To date, no evidence has been found to indicate an over-active hunger center as a major cause of obesity in humans (Bruch, 1973). However, lesions produced in the hypothalamus of rats have caused rapid weight gain (Thomas and Mayer, 1973).

The question as to whether metabolic and hormonal changes cause obesity or whether these changes are consequences of obesity remains a debatable issue. For example, obese individuals have a greater number of fat cells in their body than non-obese individuals. Accumulation of fat cells occurs because of relative inactivity or relative excessive intake of food (Bray, Davidson, and Drenick, November, 1972). Fat cells metabolize glucose more slowly than other cells, and insulin is required for the utilization of this glucose. In obese individuals the supply of circulating insulin is always above normal. Therefore, fat storage is promoted as well as glucose entry into fat cells because insulin inhibits hormone sensitive lipase in fat cells (Albrink

(ed.), 1968).

Why is there an increased amount of insulin in obese individuals? All evidence points to the fact that obesity causes insulin resistance which results in impairment of transport of a given amount of glucose into a muscle or fat cell in the presence of normal circulating amounts of insulin. Thus, there is compensatory overgrowth of beta cells of the pancreas to produce more insulin to overcome this resistance. This increased amount of insulin not only promotes fat storage but helps to maintain it by interfering with the action of hormone sensitive lipase as well (Mayer, 1968). Another compounding factor is that obese people consume large amounts of food, including many carbohydrates which serve to keep the pancreas secreting high levels of insulin and serve to increase body weight. Weight loss restores insulin levels to normal, indicating that hyperinsulinemia found in the obese individual is a consequence of obesity rather than a causative factor (Bruch, 1973).

Other hormonal disturbances seen in obesity are the increased production and excretion of certain adrenal steroids, a high level of plasma anti-diuretic hormone, decreased amount of growth hormone, and a reduced ability to excrete sodium. Yet, resulting from all of this research and reporting is still the question as to whether the above conditions are causes of obesity or the result of it (Bruch, 1973).

In an attempt to resolve this issue, Dr. C. Sims studied normal weight volunteers before weight gain, during weight gain of at least twenty-five per cent, and after their return to basal weight. He found the rates and responses of hormones returned to normal when subjects returned to normal weight (Bray, Davidson, and Drenick, 1972).

Another issue for consideration is that of the imbalance between energy intake and energy output. How does this process occur in an individual? The economics of eating and caloric expenditure may prove distressing when one reviews the metabolic balance sheet carefully. If a daily caloric intake exceeds a daily caloric output by a mere twenty-five calories (caloric content of one vanilla wafer) and if this small profit continues on a daily basis for over one year, a net profit of 9,125 calories will result. One pound of fat is equal to 3,500 calories; thus, one extra cookie of twenty-five calories a day can make an individual 2½ pounds fatter than he was last year (Spark, 1974). Dr. Jean Mayer states that inactivity is a major cause of obesity. He feels that energy output must be increased to balance against caloric intake (Thomas and Mayer, 1973).

Health Consequences of Obesity

Health care professionals are concerned with possible effects of overweight on health. Aside from the metabolic consequences mentioned in an earlier section, leading authorities are also discussing other health related aspects of obesity. For example, corpulence is often associated with arthritis, varicose veins, diabetes, gall bladder disease, hypertension, coronary artery disease, and increased mortality rates (Journal of American Dietetic Association, 1974; Craft, 1972).

Doctors have not established conclusively that heart disease, the major cause of death in the United States, is caused by eating a rich, fatty diet such as that consumed by many overweight individuals. However, their statistical case is strong in making this correlation. In Germany, for example, the rising death rate from complications of high blood pressure coincides with the increase in caloric intake that has occurred with an improvement in living standards since World War II (Time Magazine, 1972).

Obesity alone rarely increases the risk of coronary artery disease, but obesity coupled with other risk factors such as hypertension or hypercholesteremia contributes greatly to coronary artery disease (Shumway and Powers, 1973). Dr. Albert Stunkard states that the obese individual who does not have hypertension, chronic heart disease, or diabetes, and

does not smoke has only a slightly greater risk of coronary disease than his slim counterpart of the same condition (Phillips, 1973). However, it has been Dr. Ancel Keys who has shaken the doctrine that obesity per se carries an increased risk of coronary artery disease. His statistics increase the doubt as to whether obesity is a primary risk factor. Dr. Keys found that if other populational factors such as smoking, blood cholesterol, and hypertension are held constant, being overweight does not seem to increase the risk of myocardial infarction (Keys, 1972).

Obesity, however, may be a second-risk factor as it has an impact on the quality of life through impairing cardiovascular and pulmonary functions. Dr. Jean Mayer has noted that blood pressure is often increased when body weight is increased and that such elevation frequently returns to normal when significant weight is lost (Mayer, 1968). To further substantiate effects of obesity on the cardiovascular system, increased weight means greater work for the heart and the limitation of functioning is evident through measurements of heart rate, stroke volume, cardiac output, and blood pressure, etc. Also, all pulmonary function tests indicate poorer performance in the obese individual (Keys, 1955).

Surgery is also more difficult for obese individuals. For example, adipose tissue is slippery and the length of time for performing the surgery is increased because of the large amount of tissue to be incised.

Longer surgeries increase the risk of complications from anesthesia. Also, fatty tissue does not heal well because of its decreased blood supply which decreases its resistance to infection (Ramsey, 1973).

A predisposition to mild forms of diabetes may be fostered by obesity. Some obese individuals have an impaired carbohydrate tolerance and cannot utilize glucose properly (Mayer, 1968). Insulin is necessary to convert this stored glucose into energy; however, the extra fat found in bodies of obese people is insulin resistant and prevents the insulin from performing the conversion of glucose into energy. The increase in high blood sugar that results because of this insulin resistance may be of sufficient degree to be classified as diabetes. This high blood sugar has, however, been seen to disappear with weight loss (Mayer, 1968).

A further problem for obese individuals is their increased susceptibility to accidents. Overweight people are slower in crossing the streets, presenting larger targets for automobiles, and often have difficulty with balance (Ramsey, 1974). Also, obese people frequently have back and foot problems, often secondary to osteoarthritis (Geigy Report, 1973). Dr. Paul Dudley White, a renowned cardiologist, states that the greatest stress of obesity occurs in the veins of the legs. Pooling of blood is increased in the legs as valves become distended and their functioning is reduced. The return of blood to the

heart is thereby decreased and thrombosis may occur (Ramsey, 1973). Another significant area of difficulty for the heavy person is that of emotional trauma (Bruch, 1973). A discussion of this problem area will occur in the following section.

The Psychology of Obesity

According to Dr. Hilde Bruch, overeating resulting in obesity is a symptom of an underlying disturbance and not a disease (Bruch, 1957). She feels that in viewing psychological problems related to corpulence, it is necessary to differentiate between the factors that participate in the development of obesity, those that are created by the obese state in a culture that so readily condemns even mild degrees of overweight, and lastly the tension and conflicts that are precipitated by efforts at weight reduction (Bruch, 1972).

A number of psychological factors have been blamed for inducing obesity: desire for love, frustration, fear of loneliness, etc. And yet, none of these tension states adequately explain the extraordinary fact that the brain makes such a big mistake that the person

tries to relieve these sensations by eating. The answer, therefore, must lie somewhere in the psychosocial development of the individual (Bruch, 1973). The human baby has a brain capable of many potentialities. Normally, a mother should teach the infant to discriminate various sensations by hugging it when it is tense, feeding it when it is hungry, and changing diapers when the baby is wet. Most mothers accomplish this discriminatory process, but there are a number of insecure mothers who use feeding as a response to all needs. These mothers use the sucking technique as a pacifier, programming the infant's brain towards the eating process often seen in obese individuals (Ainsworth and Bell, 1969). Early eating behaviors such as these described assist in fostering developmental obesity: obesity that begins from infancy.

In developmental obesity, food is closely related to interpersonal relations. The close alliance of food to interpersonal relationships, pain, and pleasure may cause submergence of food's use for nutrition. For example, as mentioned in the preceding paragraph, a mother might comfort her child with food (Menzies, 1970; Alexander, 1950). The use of food for meeting all needs and conveying love does not matter up to a point, but may become an inappropriate response leading to a child's obesity and his passivity for activity since his activity has not been rewarded or encouraged. Feeding for every discomfort carries with it

the message: "I know what you need", so that a child never develops a concept of hunger or discomfort, or a sense of control over his own body (Ainsworth and Bell, 1969).

Certain characteristics have been noted among families of children who have been obese since childhood. Corpulence is often related to increased birth weight resulting from the mother's eating behavior preceding and during pregnancy (Crisp et al, 1970). Frequently, the mother and/or a close relative is overweight (Caldwell, 1965). The families of people with developmental obesity are usually small, and family relationships are often tense and quarrelsome with the mother appearing ambivalent and dominant and the father more submissive. The obese youngster develops an intense dependency on the mother which leads to a characteristic found in a number of those with developmental obesity: marked immaturity of behavior in striking contrast to their physical and intellectual development (Bruch, 1957; Caldwell, 1965; Hunnemann, 1974). The dependency among some obese individuals is very high, resulting in their telling their parents of every thing they do, even after they leave home and marry (Gill, 1946).

People who have been overweight since childhood often develop recalcitrant obesity, desiring to lose weight, but, despite earnest efforts, cannot do so for a sustained period (Caldwell, 1965). For individuals with developmental obesity, weight disturbance is inter-

woven with their whole growth and development and is sometimes associated with severe personality disturbance. Bruch maintains that these children fail to organize awareness of signals of bodily urges, in particular awareness of hunger as a nutritional need leading to a deficit in the regulation of food intake. "The reproach that obese people have no will power may describe a functional deficiency in proper hunger awareness" (Bruch, October, 1972, p. 12). This deficit in perceptual awareness of hunger leads to misuse of the eating function causing individuals to experience the need to eat and to be helpless in controlling these impulses (Bruch, 1972).

Dr. Albert Stunkard devised a method for studying obese and non-obese adults. Each person fasted overnight and came into the lab to swallow a Levin tube. For a four hour period, each person was asked to report whether or not they were hungry. Some of the reports were associated with kymographic tracings which indicated gastric contractions while other reports were associated with so-called "hunger contractions". In comparing the results of the two groups, it was shown that non-obese individuals were significantly more likely than the obese individuals to report hunger in association with gastric motility. Dr. Stunkard concluded that cues for obese and non-obese people are different (Stunkard, 1959). As has been illustrated, the cues for obese individuals become confused with emotional tensions, leading to the

use of eating for non-nutritional needs. Feelings of underlying depression and loneliness are seen in some obese individuals, leading to their seeking relief through eating (Hecht, 1955).

The literature concentrates heavily on developmental obesity and its psychological relationship. However, a second form of obesity does exist. Obesity may also be classified as reactive-corpulence that began after some traumatic event. During World Wars I and II, women became obese after severe mental shock such as bombing or loss of a loved one (Bruch, 1972).

A number of qualities seen by health professionals may be the result of obesity rather than its cause. For example, overweight people often feel unaesthetic, undesirable, unhealthy, morally wrong, and ridiculous (Mayer, 1968). Society looks unkindly on the obese individual with attitudes that fatness connotes weakness, laziness, and lack of self-discipline (Craft, 1972). Stunkard and Mendelson found that social pressures and attitudes can lead to disturbance of body image of some obese persons. Obesity begun in childhood may be more detrimental to body image than that of adult onset obesity. In adult onset, the people have not been found to loathe their bodies and hate themselves for being fat. However, people with childhood onset obesity see themselves as ugly and possessing few talents (Stunkard and Mendelson, 1960). Factors predisposing to the development of a disturbed

body image in obesity are: 1) Age of onset with adolescents having more problems with body image; 2) Presence of emotional disturbances in the juvenile era; 3) A negative evaluation by others during formative years (Craft, 1972).

A number of obese individuals undertake weight control behavior, to escape some of the social and moral judgment as well as to decrease health risks (Dwyer, Feldman, and Mayer, 1970). According to Bruch, some heavy people have success in losing weight, but the number who can reduce and maintain reduction is very low. Many are able to lose weight but have to stay on a semi-starvation diet to do so. These individuals become preoccupied with staying slim, and, after losing weight, become more insecure and dissatisfied, as eating had served as a defense against difficulties which had not yet been resolved in a constructive way. For these individuals obesity is their effort to stay well or be less sick, and their lives become a "see-saw" pattern of weight gain and weight-loss (Bruch, 1957).

As has been illustrated through this review of the literature on the psychological factors relating to obesity, developmental obesity receives the greatest concentration. This occurrence may be true in part, because obesity is most malignant when the onset is early (Mayer, 1968). Also, this form of corpulence presents a challenge to the health professional who is often frustrated in working with obese individuals with such a complex situation and its underlying dynamic

process. All people who are overweight do not share identical psychological qualities. However, this author has presented some of the most common psychological theories and findings from which individual assessments might be generated.

Treatment Strategies

The scope of this dissertation does not lend itself to an in-depth explanation of all of the existing strategies for treating obesity. Therefore, the author has chosen to present an overview of a few treatment plans.

A common reducing strategy, described by Mayer, is that of the reducing diet or a combination of diet and exercise. This means of weight control rests on the premise that a caloric deficit must be insured to provide weight loss. Most authorities support a program for re-education of an obese patient to improve his eating and exercise patterns. A diet that is nutritionally sound and an exercise program suited to the individual's health status, age, and preference is a sound, healthful means of weight reduction (Mayer, 1968).

Ninety-eight per cent of the weight lost through diet and exercise is likely to be fat, while seventy-five per cent of the weight lost is fat when only a diet program is followed (Stuart and Davis, 1972).

Crash diets are popular among many Americans. Such fad diets as the Quick-Weight Loss Diet, The Grapefruit Diet, and the Lover's Diet are three of the most common. Another wonder diet is the HCG glandular program consisting of a low-calorie diet combined with an injection of the human chorionic gonadotrophin hormone. This combination yields quick results with its participants reporting feelings of being euphoric and well-fed (The San Francisco Chronicle, 1974).

These fad diets are usually successful for a short period of time, and individuals become bored and return to old eating patterns. A number of health authorities criticize the crash diets that mobilize fat and interfere with the body's insulin mechanism. Fat removed from storage depots where it is doing no harm may become harmful when it enters the bloodstream. Hazards attached to some fad diets are hypokalemia and cardiac arrhythmias (Geigy Report, 1973).

Jejuno ileal bypass is a surgically induced means of weight reduction which reduces the amount of absorptive surface available in the intestine. Dr. George Bray sees this surgical process as a worthwhile measure for extreme obesity that has developed from childhood. Criteria used in selecting individuals for this treatment are:

- 1) Body weight in excess of 100 per cent over ideal weight.
- 2) Presence of life threatening complications of obesity such as diabetes mellitus, respiratory insufficiency, heart failure, thromboembolic disease.
- 3) Inability to control weight through dieting, exercise, and psychotherapy.
- 4) Absence of co-existent, treatable, metabolic disease such as hypothyroidism or Cushing's Disease.
- 5) A co-operative patient.

The major hazards in this operation are a deterioration in liver function that develops post-operatively, electrolyte imbalance secondary to diarrhea, and wound evisceration (Kaufman and Weldon, 1967; Payne and Dewing, 1969).

Drs. Stunkard and Stuart have described promising experiences with another means of weight control: behavior modification. The goal of such a program is to assist an individual in gaining control of his eating so that weight loss might occur and be maintained, and old eating patterns might be broken (Stunkard, 1959; Hanania, 1974; Stuart and Davis, 1972). For example, individuals are taught about good nutritional habits. They are instructed to keep records of everything eaten during a day as well as where it was eaten and what they were feeling at the time. Exercises of this nature serve to increase awareness. The obese are encouraged to make eating a pure experience and to disassociate it from

other physical experiences such as watching television. They are taught to confine eating to one area and to slow their rate of eating; the goal is for the obese individual to gain control over the act of eating. (Phillips, 1973; Stuart and Davis, 1972).

A further method of weight reduction that appears to be popular is that of a self-help group such as Weight Watchers. All of the people in such organizations have or have had weight problems. The approach of these groups appears to rely heavily on acceptance, with peer pressure and support supposedly increasing motivation and enhancing self-esteem (Bumbalo and Young, 1973). Weight Watcher, for example, conducts classes on diet education, publishes its own magazine, and fosters a sense of belonging through the development of its own language (using words such as "legal and illegal foods").

A combination of diet control, increased exercise, and psychotherapy is also viewed as an effective means of weight reduction. A number of patients have not been helped by decreasing calories and increasing exercise, nor has psychotherapy alone succeeded in altering the course of obesity. However, a diet and exercise program with improvement in social and interpersonal skills through psychotherapy has been successful for some people (Crisp and Stonehill, 1970). An individual's knowing the unconscious factors that further the development of his obesity has been seen as important in improving the prognosis of his

obese condition. According to Dr. Burnard Hecht, "The problem of obesity must be viewed in light of its inseparable components: the meaning of food, eating, and the obese state" (Hecht, 1955).

In conclusion, the researcher has presented a review of the literature on obesity to further expand the scope as well as the depth of comprehension. The review also provides the necessary background for the study of obesity as presented in the following chapters.

PART II - THE CONCEPTUAL ENTREE

CHAPTER IV - THEORETICAL FRAMEWORK AND METHODOLOGY

As noted from the previous review of the literature, a great deal of work has been done to investigate the clinical and psychological components of obesity, but little to view the aspect of living with obesity in today's society or to determine the various meanings of obesity to its population. From her nursing experience, the researcher has seen the gaps that exist in health care delivery to obese individuals and the resulting poor success rate of weight reduction; therefore, she chose to take the perspective of clinically defined obese individuals to determine their views of obesity and its effects on their lives. Questions that led to the selection of this approach were the following: 1) After being supplied with risk factors connected with obesity via health professionals and/or mass media and being provided with tools for countering obesity, why do obese individuals not play the "health game" and lose weight? 2) What might be missing in the health avenues offered to obese individuals via health professionals and/or health institutions? 3) What alternative or new plans can we as

health professionals provide? It seemed that a logical beginning for answering these questions might be with obese individuals themselves; for how can health professionals propose to work in an area such as obesity without first exploring its various components in depth. The field method with its watching and listening (interviewing as conversation) provided the mechanism to acquire the data on how obesity related to the day-to-day lives and thoughts of corpulent individuals.

Framework

Guiding the framework of this study were concepts drawn from the general theoretical perspective of symbolic interactionism. The term "symbolic interactionism" is applied as an approach to the study of human group life and human conduct. Its empirical world is the natural world of group life and conduct (Blumer, 1969). The symbolic interaction in this natural world is the interaction that takes place between human beings (Rose, 1962). Also, insofar as human beings are social and take attitudes toward themselves, they may be said to be self-interacting, as in thinking about themselves. The school of thought related to symbolic interactionism emphasizes the processual character

of human behavior and the need for more introspection in the study of this behavior (Davis, 1972).

A naturalistic approach was utilized to view the symbolic world of the obese individual and the realities he had constructed around the "is's" and "because's" of his obesity. The "is" revealed the objectified content of an individual's designations as well as his reasons and processes" the logic of his thinking (Schatzman, 1973). From the symbolic interactionist perspective, man lives in a symbolic world, created and named in the process of relating to others and from which he defines the ways in which he will act (Blumer, 1969). Preliminary to any self-determined act of behavior, a stage of deliberation and examination may be identified as "the definition of the situation". To a symbolic interactionist, determining an individual's definition of a situation and his identity in that situation is important; for a person's life-policy as well as his personality may follow from a series of such definitions (Thomas, 1972).

Three premises furnish the foundation for symbolic interactionism:

- 1) People act toward things (others, self, values, situations) in terms of the meanings these have for them, 2) Meanings derive from or arise out of social interactions that one has with others, and 3) These meanings are modified through interpretive processes one uses in dealing with things he encounters (Blumer, 1969). The meanings that things

have for human beings are constantly being modified and to ignore these meanings is seen by the symbolic interactionist as falsifying the behavior under study (Blumer, 1969). In addition, each human being is an individual determining his meanings for situations, meanings that may change with the individual through his experiences in the process of "becoming" (Manis and Meltzer, 1972). Thus, symbolic interactionists focus on interpersonal relationships and the meanings the individual ascribes to a situation, object, or event, including those associated with himself. To determine meanings and identities of individuals, one must go directly to the empirical social world where he may observe and hear what is occurring within the on-going group life (Blumer, 1969). The researcher must view human conduct from the point of view of those he is studying, "taking the role of another" to learn the other's language and to capture his salient views of himself. Taking the role of the "acting other" (the person being observed) prevents substitution of one's own perspective for that of the individual he is studying (Denzin, 1972).

Methodology

The methodological format that assisted in the attempt to capture the symbolic universe of obese individuals within their natural environment was that of field research. Field research permits one to seek what is rather than predict relations to be found, and of the methods open to researchers, field studies are the closest of all to real life (Kerlinger, 1964). Through use of observations and interviews, attempts were made to characterize and explain the commonalities found among obese individuals. Extensive examination of the respondent's present situation as well as past experiences in living with obesity was done through use of an interview with particular emphasis on data such as the meaning of obesity to obese individuals and effects of obesity on their everyday lives. Data analysis was ongoing with analytical categories evolving throughout the research process. In analyzing the data, diverse bits of information were drawn together into a unified interpretation resulting in the generation of a conceptual model that will be presented in the following chapter (Jahoda and Sellitz, 1959). For clarity of presentation, the description of the research process will be divided into three phases: preparatory phase, actualizing phase, interpretive phase.

Preparatory Phase

The researcher had worked with obese individuals and observed their behavior in a variety of settings such as clinics, hospitals, and health spas. Assuming the role of either observer or participant observer, extensive notes were recorded and organized for a possible dissertation. She watched corpulent individuals struggle with weight reduction and observed their interactions with other obese people and health professionals. Conducting a counseling group for obese women afforded her further background material for the study and led to the present research format: to talk with obese individuals in order to gain a clearer grasp of the complex condition, obesity, from the perspective of obese individuals themselves. No previous models for research of this nature could be found within the area of obesity; therefore, in a sense this project is a pioneer work. Psychological and physiological studies regarding obesity are abundant, but none approach the area from the experiential reality of the obese individual.

A. Selection of Site

Paramount to beginning the study was selection of a site or sites.

Once a researcher has his focus of interest he must locate a site that contains people and social activity bearing upon that interest (Schatzman, 1973). Individuals defined as obese by physicians were selected from the following facilities: comprehensive medical clinics, obesity clinics, health spas, and private physician's offices. Entree was gained into the sites by negotiations with individuals in charge and explaining to them the purpose and plan of the study as well as the interview tool to be used.

B. Development of Tool

The interview tool or schedule was developed and pre-tested with four obese persons who were attending an obesity clinic. Questions were developed to determine the meaning of obesity to each individual and the effects of obesity on his everyday activities, eg., dress, family life, occupation, sex, health. (See Appendix for interview format). Though a definite format was designed and carried as a reminder to cover all salient areas, every attempt was made to maintain the atmosphere of conversation. The word "obesity" was not used during the interview as the pilot interviews revealed a poor understanding of the term by the lay public. The terms "overweight" and "fat" were

used instead.

C. Selection of Sample

The criteria for selection of the population to be studied were:

- 1) Minimum age of eighteen years
- 2) A diagnosis of obesity made by a physician
- 3) Excess weight of at least twenty pounds above normal weight for height, bone structure, and sex as in Metropolitan Life Insurance Standards

Both male and female respondents were to be interviewed when possible, and no discrimination would be made as to cultural or ethnic origin.

Actualizing Phase

Permission was secured from the agencies mentioned previously, and potential respondents were contacted via telephone or during their visit to the agency. The following were components of the information given and the contract made with the clients:

- 1) The investigator was a doctoral nursing student conducting research in the area of obesity.
- 2) The time commitment for the client was approximately two hours for an interview in which a tape recorder would be used.
- 3) The purpose of the research was to gain information about obesity that could further understanding of this area and possibly improve future care for obese individuals.
- 4) Anonymity of the client would be assured as no names would be used at any time, and the researcher would be the only person to hear the tape recordings.
- 5) A verbal consent to participate in the research was obtained.

After the contract was made, most of the interviews were conducted in the participants' homes in order that the respondents might be more comfortable during the interview. Three interviews were conducted in a physician's office at the request of the respondents. The participants were cooperative and eager to discuss their obesity. In fact, some respondents indicated that it was nice to talk with someone who seemed to understand their problem. One subject revealed that being interviewed had motivated her to lose weight, as the fact that she had been identified as overweight and asked to participate in the study increased her awareness of being fat.

The interviewer did not use a specific list of questions because

this amount of formality would destroy the conversational style. However, a general topic outline for the interview was followed, as illustrated in the Appendix, in order to secure the same categories of information from the participants while attempting to provide an interview style natural to the respondent and the interviewer (Schatzman, 1973). Interviewing strategies that were helpful were nodding to encourage further discussion, verbally reflecting on the respondent's expressed thoughts and probing for clarification and expansion of thoughts (Adams and Preiss, 1960).

Interpretive Phase

Analysis is an ongoing process that begins with the initial collection of data (Schatzman, 1973). The researcher interacted with the collected data through consistent interpretation and categorizing of the information. Data were organized into Observational Notes (ON), Methodological Notes (MN), and Theoretical Notes (TN). The ON's consisted of statements concerning material gathered through watching and listening. These statements contained as little interpretation as possible and represented an effort to record reliable data and to determine the who, what, when, where, and how of the obese

2
individual's world. Methodological notes were used to assist in improving interview tactics and in critiquing methodological process. The MN's represented an ongoing evaluative process that was used in assessing progress and planning future strategies. Theoretical Notes provided conceptual linkages of Observational Notes and the theoretical classifications that later formed the analytical base (Schatzman, 1973).

A. The Sample

The sample consisted of twenty women whose age range was twenty to sixty-five years with weight ranges from forty to two hundred and fifty pounds in excess of normal weight. Men were not included. Respondents were composed of Caucasians, Blacks, Chicanos, and Italians among whom were professionals, housewives, and skilled and unskilled workers.

The annual income of the family was the criterion on which the determination of economic classification was based: \$0 - \$10,000 (I); \$10,000-\$20,000 (II); \$20,000 + (III). For a diagrammatic illustration of the sample, refer to Table, page 60.

Table I: The Sample

Name J.	Age 25	Sex F	Weight in Pounds 217	Height 5'8"	Marital Status S	Occupation Student	Education (Jr. Coll.) A.A.	Income Level** II (in \$000)
B.	29	F	165	5'2"	S	Teacher	(Coll.) M.S.	II
R.	46	F	300	5'5"	M	Domestic	Grammar	I
C.	48	F	170	4'11"	D	Unemployed	8th Grade	I
O.	50	F	325	5'5"	M	Apt. Manager	10th Grade	I
P.	52	F	185	5'4"	D	Housewife	10th Grade	I
B.	39	F	214	5'3"	M	Housewife	1 yr. Coll.	II
A.	36	F	307	5'10"	M	Nurse	(Jr. Coll.) A.A.	II
M.	36	F	170	5'	M	Housewife	1 yr. Bus. Coll.	II
D.	41	F	235	5'6"	M	Domestic	8th Grade	I
S.	23	F	198	5'	M	Housewife	H.S.	II
N.	20	F	229	5'3"	S	Beautician	H.S.	II
A.	65	F	235	5'4"	M	Housewife	5th Grade	I
W.	63	F	188	5'4"	M	Domestic (R)*	9th Grade	I
W.	27	F	169	5'5"	S	Teacher	Coll. M.N.	II

* (R) = Retired
(W) = Widowed

(S) = Single
(M) = Married
(D) = Divorced

** I = \$0 - \$9,999
II = \$10,000 - \$19,000
III = \$20,000 or more

Table I: The Sample, cont.

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Weight in Pounds</u>	<u>Height</u>	<u>Marital Status</u>	<u>Occupation</u>	<u>Education</u>	<u>Income Level</u>
Z.	39	F	189	5'5"	S	Teacher	Coll. 2 yrs. post masters	II
S.	53	F	215	5'3"	W	Secretary	H.S.	II
M.	37	F	204	5'5"	D	Secretary	H.S.	II
P.	43	F	195	5'4"	D	Bus. Manager	H.S. - 1 yr. Bus. Coll.	II
M.	36	F	201	5'4"	S	Teacher	Coll. M.S.	II

B. Conceptual Model

Ongoing analysis of the data led to the development of organizational categories; Dress, Social Life, Occupation, Sex, and Mobility and an overall scheme to encompass all that was heard and seen during data collection. Further data analysis resulted in the conceptual model of obesity as a career. Therefore, "career" became defined as a course of events around some identity or dimension which, when abstracted, constitutes a pattern of some piece or all of a person's life. As this conceptual model evolved, the central focus of the research became obesity as a career regardless of ethnic group, age, or sex. Its emergence, and supporting data will be presented in the following chapter.

CHAPTER V - OBESITY AS A CAREER

Analytical Process

Data analysis was a constant process with classification and comparison of the data throughout. The technique of constant comparison precluded the usual technique of waiting for all data to be collected before beginning analysis. Information obtained through each interview was compared with that of previous and succeeding interviews to determine consistent as well as unique properties and categories. This analytical process was an attempt to generate theoretical ideas: new categories and their properties, as well as hypotheses, resulting in a redesigning and re-integrating of theoretical ideas as the researcher reviewed the material (Glaser and Strauss, 1971).

Throughout the interviews a variety of expressions and events were reported by the respondents: feelings of disgust, exhaustion, worry over the possibility of losing one's husband, difficulty in

purchasing pretty clothes, etc. While the researcher did not witness the actual events reported, she did experience instead the respondent's telling and expressed feelings about events such as shopping for clothes and suffering the ridicule from others. The data revealed a pervasiveness of pre-occupation with weight, and the respondents were glad to discuss their weight in a manner they had not experienced before. Statements revealed throughout the interviews provided multiple indicators of meanings and themes. For example, one statement, "I can't stand myself in these horrible 'old lady' dresses I have to wear", was an expression related both to disgust with one's self and shopping for clothes. In order to promote the organization and utilization of such statements, it was necessary to develop a classification scheme of codes. This was done by assigning a key thematic word for each phrase. In this way it was possible to capture in abstraction the referent for the phrase. For example, a phrase such as "I guess I'll always be fat" was seen as indicating self-reference; whereas, the phrase "I look horrible in the tent dresses that I have to buy" indicated reference to clothing or shopping for clothes and to self-conception. By examining every phrase recorded it was possible to conceptualize themes and their reference for use as a coding scheme. As might be expected, many respondents' phrases exhibited multiple references,

and these were multiple coded.

This process of preliminary analysis which is seen as code-building and coding yielded a limited number of key categories which formed themselves into five general classes: Dress, Health, Mobility, Social Life, Body Image. These five general classifications which were most universal, emerged from the language of the respondents, insuring that the final categories would be empirically grounded. This process was utilized with each case, which enabled one to ascertain which of the categories were being used again and again (universally), which were less than universal, and which were more idiosyncratic. The latter two were then eliminated from any further consideration. As previously mentioned, the five categories listed above became representative of the core variables for data analysis. Each of these core variables is itself an abstraction of a number of subsidiary themes. Thus, the variable of mobility is an abstraction not only of movement and space, but also of expressions of being tired and being unable to fit into the seat of a sports car.

A search began for a single process to serve as a key link for all of these variables. From her sociological and nursing perspectives in questioning the data, the researcher began to see the unfolding of a conceptual model: obesity as a career. The reading of Outsiders by Howard Becker and discussions with her research sponsor enabled the researcher's variance of perspective and furthered

the linkage of "career" to the process evolving from the data concerning obese individuals. Becker, in attempting to develop sequential models for various deviant behaviors, utilized the concept of career. Career, as described by Becker, refers to a process, stages of development within a system. Also included in this model is the idea of career contingency or those factors on which mobility from one position to another depends. Such factors include both objective facts of social structure and changes in the perspectives, motivations, and desires of the individuals (Becker, 1973).

Webster defines career as a "course, passage, or course of continued progress" (Webster, 1967). The research data also supported the momentum for conceptualizing obesity as a career. Respondents indicated that trying to lose weight was a full time job and being fat was a way of life. All core variables could be represented as processes having characteristics of careers. For example, changing the categorical noun, dress, to the verb, dressing, further illustrates dressing as a process experienced by the obese individuals: the steps and problems in purchasing and wearing clothes. The utilization of the concept of career permitted the researcher to change her categorical classifications from nouns to verbs: Dressing, Ambulating, Health Caring, Socializing, and Body Imaging. This change could enable the researcher to develop each of the core variables separately as a career and then interrelate them to each other in

such fashion as to suggest a theory of obesity from the perspective of the obese person.

After this process of reduction of terminology and consequent generalizing and constant comparisons, this researcher achieved two major requirements of theory construction: 1) parsimony of variables and formulation and 2) scope in the applicability of the theory to a wide range of situations (Glaser and Strauss, 1971). The theory thus generated from this analytical interaction with the data was that of obesity as a career. Career as utilized by the researcher was a course of events around some identity (obesity) which when abstracted constituted a pattern of some piece or all of a person's life. In the process of experiencing these said events or processes, the lives of the obese individuals were shaped as well. The flexibility in the application of the theory developed through this research will be illustrated in the final chapter of the dissertation. A diagrammatic scheme of obesity as a career with descriptive data will be presented in a later section of this chapter.

The analytical process described in this section led to a more solidified theory with a workable number of universal categories for collecting and coding data within the boundaries of the theory. Theoretical saturation occurs when the researcher has coded incidents for the same category a number of times and subsequently is collecting

no new aspects (Glaser and Strauss, 1971). With theoretical saturation came the decision to cease data collection and begin the organization of analyzed materials for writing. The researcher was convinced that the data supported a conceptual model of obesity as a career and that the collation of materials could begin.

Data Sketch - A Long Struggle with Fat

The following is a data sketch illustrating what was heard during the data collection process. Mrs. M. is a thirty-seven year old divorcee whose employment as a legal secretary helped her to support her three children. This respondent had long suffered the anguish of being overweight and was eager to discuss her obesity.

Mrs. M., a woman of five feet five inch stature, weighed 204 pounds at the time of the interview. She had been overweight as long as she could recall. "I was a plump child who came from a Jewish family where the table was laden with food. Food represented love and a way of making everybody happy." Her parents were constantly prodding her to reduce the amount of food that she consumed. Their

attitude was that a strong person would not get fat: heavy people lost control and let themselves go. At the time of the interview, Mrs. M. was still receiving the same message from her family: she had to be strong and gain control as she had permitted herself to gain sixty pounds in the two years since her divorce.

The respondent had always thought of herself as a fat person. Her weight seemed to have a hold on her identity, for even when she weighed 120 pounds during her early twenties, she retained the feeling of being fat. When asked about her social life, Mrs. M. reported that as a child she had often been teased and had worked vigorously to lose weight during the dating period of adolescence. At the time of the interview she was struggling with her self-concept: a woman who was fat and feeling trapped within a massive body. She was dating sporadically and had found some men who liked fat women. Mrs. M. had decided not to date any man to whom her weight would make a difference. Yet, she was constantly bothered with what people thought about her and her weight. "Even if a man does not mind looking at fat, is he going to want to feel it?" She felt that various media such as television and magazines flashed the image of the thin, beautiful woman and this was the goal for all women to achieve. "You may look at me and think fat, but that does mean I am fat. It isn't something inherent within me. It's like people say

you don't look Jewish; it's exactly the same thing. There is no standard but we get double messages in society: someone says you must look just like this and you ask - what is just like this? Nobody agrees, yet we assume that all men want a beautiful woman, and beauty is being thin."

Feeling less attractive and wanting to be more socially accepted were only two of the problem areas for Mrs. M. To this woman, the words "fat", "obese", "overweight" were all negative. She felt that obese people were looked down upon and made to feel different by everyone, including physicians. She had recently gone to a physician for a yearly physical and was told that she was in excellent health but that she needed to lose weight. "He stood there all tanned and trim and looked down his nose to tell me that I was too fat. I've gotten the same type of message from other doctors at one time or another, but I don't need them to tell me in their condescending manner that I'm fat; I know it, I feel it, and I live it."

Mrs. M. felt that her weight affected her health to a very minor degree. She felt that she tired faster but still had enough energy to function. "I can't run up hills, but I don't care, as I have no desire to run up hills." To Mrs. M. her greatest energy consumption was of a psychological nature: having her weight on

her mind constantly and worrying about what to eat, how to hide fat and make herself more attractive. "Being fat is a way of life and trying to lose weight is a full time job." She had trouble buying clothes that she wanted to wear so she wore caftans to hide her fat. She had not yet resorted to primarily dark colored clothes but saw this as another avenue open to her to disguise her body. "My size limits my freedom of choice of clothes."

Mrs. M. did not feel that her weight was affecting her employment at the time of the interview but felt that it might make a difference in the next two years if she decided to change jobs. When asked to describe her outstanding problem related to weight, Mrs. M. said that it was feeling unaccepted or looked down upon others. "People consider being fat a weakness and judge me. I want to be accepted and just wish that I had some vice that did not show. Whether I like it or not, there are some people who are going to judge me. These thoughts are in my head, and I get the same feedback from people." Mrs. M. was motivated to lose weight at this point in her life because of the problems described above and because she could no longer tolerate feeling like an outsider. "Being fat makes a difference in our society. I am not an island to myself but an organism, and I'm cutting myself off in many ways if I insist on being fat."

At the time of the interview, Mrs. M. was participating in a medical weight control program and had lost twelve pounds in two weeks. She had been on a multitude of diets throughout her life but always regained her weight. This respondent was hopeful that she would be successful for a longer period of time. Mrs. M. was afraid of failure but seemed encouraged with her twelve pound loss. One of her greatest problems had always been the fear of being physically hungry; thus, she had always eaten before becoming hungry. Hunger had represented a sense of being deprived; not being allowed something that is essential to being." With this medical weight control program she had learned that she could live through hunger.

At the time of the interview, Mrs. M. was still grappling with the question: why should it matter if one person weighs twenty-thirty pounds more than someone else? However, her concern about what people thought and her need to be accepted led her to begin another course of weight reduction.

Mrs. M., like respondents described in Chapter I, was a person struggling with common everyday problems. Yet, much of her identity and many of her problems were related to her being fat. Therefore, much of her life was centered around her identity as a fat woman, suggesting the conceptual model of obesity as a career. Career again

being used as a course of events around some identity or dimension which, when abstracted, constitutes a pattern or history of some piece or all of a person's life.

Properties and Indicators of the Obese Career

The five variables to be explained in this section are all important elements in the career of the obese. These variables are universal, nevertheless, they vary in importance for the people in the sample. Everyone suffered from problems around these five properties, but their responses to them differed. For example, the housewife who does not have to work has less of a problem with presenting herself in public than someone who has a job. The respondents, therefore, had variability in problem areas. While the key variables will be taken one by one and separately, the reader should bear in mind that all the variables together, as they manifest themselves in the lives of these obese people, are to be seen as components of a life career.

Dressing

A quote from Kahil Gibran's The Prophet illustrates the importance of clothes and dressing. "Your clothes conceal much of your beauty, yet they hide not the unbeautiful. Though you seek in garments the freedom of privacy you may find in them a harness and a chain" (Kahil Gibran, 1962, p. 25).

A number of people may take for granted their ability to enter any clothing shop and find clothes that are their size. The sample indicated that for obese individuals dressing themselves in desired clothes all too often proved problematic. Dress manufacturers, being geared to thin models, leave obese individuals on the edge of fashion, leading to their frustration. All of the sample in varying degrees suffered the problems of dressing themselves and appearing in some reasonable fashion in public. All women, to some extent, are concerned with this process of appearance through dress, but for obese women it is an exceptionally difficult problem since stylists and manufacturers seem to be in a "conspiracy" for reasons of profit making against heavy people. Therefore, any given retail establishment is likely to not have dresses of outsizes, or if they do, there is so little variety that there is tremendous frustration for these corpulent women. The obese suffer because designers and manufacturers

do not cater to extremes of the Bell curve.

To illustrate problems in dressing, Mrs. R. and Mrs. C. both expressed difficulty in purchasing clothes to fit them and stated that they had few clothes as a result. Miss N. and Miss S. revealed that they could buy clothes, but the clothes they purchased were not pretty. Mrs. M. described her clothes as "tents" and stated that she was tired of wearing the same style. Miss J. resorted to wearing plain, dark clothes, as bright, figured prints only exaggerated her size or brought attention to it. Miss W. wanted to be able to buy smaller sized clothes, clothes that had some shape. "I would buy more clothes if I were slim." Mrs. O. tugged at a girdle every morning in order to mold her three hundred pounds into some manageable shape. After struggling with a girdle, Mrs. O. manipulated her upper torso with a long-line brassiere to cinch the bulges at her waist that were created by the girdle. "I feel as though I'm in a straight jacket, and it takes me over thirty minutes each day just to squeeze myself into these harnesses."

Buying clothes becomes a problem and gains import in obese individuals' lives, because so much effort is required to struggle with this situation. After all, this relates to what one does with one's body image: finding clothing that will enhance those features of the body that figure in appearance and hide those features of the

body that depreciate one's body image.

Ambulating

In varying degrees all of the sample had some problem in ambulation. The word, ambulation, is not to be taken as a literal term like walking twenty miles, but it is also to be associated with going from place to place and having to worry about appearance, etc. One dimension of ambulation is fatigue as illustrated by some members of the sample. Mrs. F., who worked as a domestic, complained of being tired and short of breath. She had more energy and could do more work when she was thinner. Mrs. A., who worked as a nurse, related that she tired early and her legs bothered her more when she was carrying so much weight. Problems of a similar nature were expressed by Mrs. M. and Mrs. D. A further dimension was awkwardness in walking or running as described by Mrs. W. Mrs. S. was unable to participate in sports with her husband as a result of her increased weight. Another respondent, Miss Z., felt less agile in physical activity such as tennis.

Mrs. O. had difficulty squeezing herself into seats in some of the movie theaters as well as lifting her body in and out of cars. "I hate small sports cars for this reason. And every time we go out I have to worry about whether I can fit my huge body into chairs or seats." Miss W. often felt embarrassed when double-dating and having to sit in the back seat of a car. "I have to be pulled out of the car, and I feel so bulky and awkward." Mrs. C. had learned to select chairs carefully when visiting with people, because she had been embarrassed when not able to push her body out of a soft chair. Another respondent, Miss B., worried about going on a picnic with a date, because she was awkward in physical activities. "If we have to climb or walk very far I feel so embarrassed, because I huff and puff like a steam engine. Having to be tugged up and down hills by a date is certainly not pleasant."

Health Caring

To some extent all of the sample, if not concerned, were certainly cognizant of relationships between weight and the possibility of health problems. Surprisingly, concern for physical health as

it relates to an incentive to lose weight was not as prominent as a researcher in this area might anticipate. Indeed, in only three of the twenty cases in this sample was health first or second in priorities for engaging in weight control.

A most representative example of incentive for weight controlling is the case of Miss B. This woman felt "awkward" because of her bulky size and "huffed and puffed" when she went on walks with her boyfriend. Her primary concern centered on acute embarrassment because of her weight. The relationship of her corpulence to her physical health or to potential health risks was not prominent in this instance. Miss B.'s motivation to lose weight came from embarrassment rather than from a health-related concern. Perhaps an individual must experience a rather extreme physical manifestation such as angina or dizziness before realizing the potential health hazards of obesity for him or herself. A similar phenomenon is that of the smoker who continues to smoke regardless of warnings from health and government authorities. Many individuals may think that the health problems resulting from obesity and smoking could happen to other people but not to themselves.

A number of the obese women's complaints centered around minor discomforts such as back pain and difficulty in bending. Mrs. A. and Mrs. R. had trouble with varicosities, and this circulatory problem combined with their weight, caused them to have leg pain when re-

maining on their feet for long periods of time. Mrs. D. and Mrs. W. both suffered from hypertension and resulting dizziness. Physicians had instructed both of them to lose weight in order to reduce their blood pressure. Mrs. C. had increased arthritic pain in knees and ankles as a result of her weight gain, and Mrs. A. had been told by physicians that her heart failure was worsened by her increased weight. For Mrs. F., her problem centered around having recurrent indigestion from overeating. Mrs. O. had a painful abdominal hernia and was told that the risk of surgery for this problem was too great without weight reduction.

Some respondents like Miss A. and Miss B. were thinking ahead and wanting to lose weight before reaching the age of forty when the potential for health problems is increased. Generally, health problems in relation to obesity were not ranked as the priority problem by members of the sample. As mentioned previously, this fact came as somewhat of a surprise to the researcher as health implications of obesity are so publicized today. As illustrated by the sample, trying to maintain optimum health can become problematic for some individuals when body fat is increased.

Socializing

This category was divided into two sections in order to clarify analysis: relating intimately and relating socially. All of the respondents identified problems in the social aspects of their lives that were related to their obesity.

1) Relating intimately

Unmarried members of the sample such as Miss N. and Miss J. felt that no man would want to date a fat woman. Mrs. M. wanted a man to enjoy touching her rather than have him cringe as he touched a "mass of fat." Mrs. O. who weighed more than any other member of the sample (325 pounds) felt that she was lucky to have a man who loved her in spite of her weight. Mrs. C. and Mrs. R. described their lives as hectic and full before they gained weight and thought their husbands were ashamed to take them out because they were so fat. Mrs. M. was embarrassed to let her husband see her fat body. "Being fat makes me feel more inhibited in relating sexually with my husband."

The sample illustrated a need common to many people: that of being loved and admired by significant others. As described by Maslow in his hierarchy of needs, the need to be loved and to be accepted is of key importance to man (Maslow, 1962). As Mrs. S.

expressed, "My husband pays more attention to me as I lose weight." Miss W. was afraid of losing her boyfriend because of her weight; he had begun to tell her that he wished her to be thinner. Miss B. worried that when a man hugged her he would feel a bulge of fat and feel repulsed or "turned off".

2) Relating Socially

Socializing with friends and peers represents another important area for man as a social animal (Dubos, 1968). The sample again indicated problems in the area of relating socially with others. Miss W. liked to swim but would no longer go to a public swimming area because of her shame at being seen in a bathing suit. Mrs. M. and Mrs. C. were both ashamed to be seen by friends and thus remained indoors alone as much as possible. Miss N. was often teased and felt that she was not asked to the senior prom because of her weight. Miss A. reduced her amount of social activity because she hated the few clothes she had to wear. Miss J. felt uncomfortable and shy when meeting men because of her weight. "I seem to have lost confidence in myself. At parties I usually sit with people I know rather than trying to make new acquaintances. I feel very self-conscious when I eat the 'goodies' because I wonder what people think when I feed my fat face."

Body Imaging

The term body image refers to "the way an individual's body appears to that individual" (Fisher and Cleveland, 1968). The way one appears to oneself arises out of interaction with others. This appearance is a function of the "looking glass self" (Cooley, 1902). In other words, seeing oneself is a reflection of how one imagines he appears to others. In varying degrees, the way all of the women saw their bodies was closely related to their obesity.

Miss W. expressed dislike of herself. "I hate my body. I look in the mirror and see a mass of bulges and wrinkles." A number of the comments centered around feeling unattractive to the opposite sex. For example, to Mrs. R. fat men were ugly and she transferred the same interpretation to herself in the eyes of men. Miss J. stated, "What man wants to look at my fat when he can look at smooth feminine lines. I'm so out of shape." Mrs. B. was ashamed for her friends to see her and thus had reduced her social activities. She also felt that her husband no longer desired her because of her weight. Miss N. saw herself as "a big blob of fat. I am tired of being called a cow." Another respondent, Miss B., indicated that if she disliked her body because of her weight, how could she expect other people to feel differently. "I often wonder how other people

see me. Do they look at me and see fat?"

The common theme among the properties of this category related to body imaging was that of feeling undesirable and looking unattractive to themselves and to others. None of the women saw obesity as a desirable attribute. Mrs. F. felt like a "vulture" who had no control over her appetite. Another descriptive comment was from Mrs. M. who felt as if she were wearing a large overcoat from which she had trouble escaping.

Imagery about oneself which relates directly to self-esteem is a crucial area. A person's body is his domain which has been found to be a significant frame of reference for his making many judgments. From knowledge of how a person has organized his perceptions of his body one can begin to assess some of the basic feelings that a person has about himself as a separate being. A person's body is the one area in his experiential field that belongs uniquely to him and represents his base of operations in the world (Fischer and Cleveland, 1968).

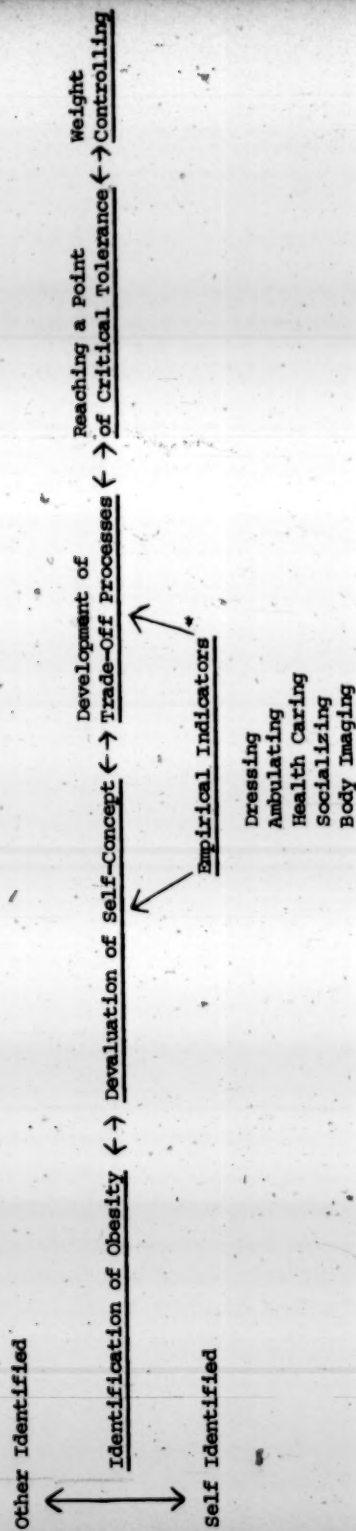
A common theme revealed through the previously illustrated categories was that obesity affected or limited the lives of obese individuals in some way, whether it was in the area of dressing their bodies or forming images of their bodies. A second component of the categorical theme was that within the process of living with the

identity and effects of obesity were certain action components: ambulating with increased weight, health caring with extra fat on the body, etc. To link the categories or core variables and to utilize and illustrate their supportive data and processes, the conceptual model of Obesity as a Career was developed.

Conceptual Model - Obesity as a Career

The conceptual model, Obesity as a Career, is a process composed of interrelated stages. The nature of process is sometimes hidden by the linear property of writing, but the reader is encouraged to think in terms of process when reading the description of the following conceptual model. The diagram of the conceptual model presented on the next page may be dealt with as universal within the context of at least three general conditions:

- 1) Personal and social definitions of obesity
- 2) Obesity seen as having negative value
- 3) Obesity is persistent

DiagramOBESITY AS A CAREER

* Empirical Indicators derived from data in this study; although most prominent here, these are not necessarily exhaustive of all indicators.

Identification of Obesity

Following Becker, a career begins with the person's identification of himself as occupying a particular status or exhibiting a particular condition. As applied to obesity this would mean that a career in obesity begins at the point at which the person involved identifies himself as obese (Becker, 1973).

All of the sample had become obese in a variety of ways, but a self-identification of obesity does not necessarily follow from being obese in the objective sense. A realization must occur for a person to identify him or herself as obese. From a theoretical point of view this self-realization of being obese is not likely to happen except through interaction with others who, in one way or another, indicate "you are fat". In this case, one becomes alerted to the reality of his obesity. An identity of being obese arises from a combination of the individual's reaching this identity and others making this identity. There is no way one can identify him or herself as obese without some indicators from the outside. Either the individual or another significant other is the key social instrument for this realization. Sometimes people reach this realization without any significant incident, but, in other cases, it was an important incident, usually within a social situation that brought

the realization of their obese identity about. In every instance the individuals in the sample identified themselves as experiencing or having an obese career.

Devaluation of Self-Concept

After entrance into the Career of Obesity (attaining an identity as being obese), the data revealed that corpulent individuals experienced devaluation of their self-concept. Self-concept is composed of ideas or feelings about oneself which includes identities based on marriage, job, and other roles as well as life experiences and how an individual sees his body (Berscheid, Walster, and Bohrnstedt, November, 1973). One's self-concept is developed out of the reflected appraisals that others have of him. People respond not only to what a person says and does, but also to his appearance: clothes, grooming, and physical attributes (Cooley, 1902).

From the symbolic interactionist perspective, self-identity is a central feature in the components of mind, self, and society. Homo-sapiens are born into a group which already has an ongoing culture. At birth, man has no mind or sense of self as the self and

mind emerge in interaction with the group. Through the use of symbols and symbolic interaction one learns about himself and the world. His mind and self arise from self-indicating interactions such as: go wash your face, you are a good girl, you are a handsome boy. After a time of taking in appraisals about oneself, an individual reaches a point where he can take his own role and look at himself and say, "I am good, I am thin, I am fat". An individual sees himself through the symbolic references society gives to him (Mead, 1962). For obese individuals, as illustrated through the data, being fat in Western society today is filled with anguish. Western society does not approve of fat bodies, and, thus, obese individuals experiencing this social standard have identified problems in health caring, socializing, body imaging, etc. These identified problems affect their self-perception and functioning within this designated society and its many sub groups and cultures.

The data and the review of the literature revealed a close relationship between obesity and the devaluation of the individual's self-concept. Wearing clothes that were not pretty and buying clothes at a special store contributed to the samples' not liking themselves as fat. Dislike of their appearance was further illustrated through comments such as: "I don't like myself, so how can I expect others to like me"; or, "I hate my body". The image one has of his body

affects one's self-concept as "body image is a sensitive indicator which registers many of the individual's basic social relationships, especially those early involved in his development of a sense of identity (Fischer and Cleveland, 1968).

Developments in growing consciousness through persistent self-other validation of indicators of obesity were further illustrated by respondents experiencing increased feelings of undesirability to members of the opposite sex. Having difficulty in moving about or dealing with fatigue and health problems also brought changes in self-concept. A number of the respondents felt different from the thin people around them and experienced feelings of awkwardness and clumsiness. The core variables differed in their problematic intensity for each of the respondents, but each process illustrated through the variables reinforced the respondent's obese identity, and, to varied degrees, devalued her self-concept.

Developing Trade-Off Processes

To counter a devalued self-concept, processes are developed

by an individual to deal with the core variables that prove to be most problematic and significant to him. The strategies that are developed are known as Trade-Off Processes. Trade-Off Processes are observable actions or strategies used by obese individuals in dealing with the priority problems related to their weight. These problems serve to reinforce an obese identity and devalue the self-concept. Therefore, the development of Trade-Off Processes is an attempt by the individual to reach a more constructive state of equilibrium for his feelings about himself. In other words, if an individual cannot rid himself of the fat, how can he manipulate his problems to make them more tolerable? What strategies can he select that will offer the greatest benefit at the least expense? To illustrate, the respondent who had trouble buying desired clothes learned to sew so that she could have the clothes she wanted. This made her feel better about her appearance in public. She felt more in keeping with the style. Another woman moved from wearing bright patterns to dark colors in order to achieve a more slimming effect. Avoidance of tight, body-clinging clothes and utilization of caftans were other strategies to camouflage fat. One woman learned to accentuate her positive features through use of make-up and supportive undergarments. The respondent who was ashamed to be seen in a bathing suit stopped going to public bathing areas. If she did go

swimming she selected a time when only a few people were likely to be there and wrapped a towel around herself before entering or upon leaving the pool. Thus, individuals selected a variety of Trade-Off Processes dependent upon their personal preferences and their problem area in order to protect themselves and to improve their devalued self-concept.

Reaching the Point of Critical Tolerance

Attaining an obese identity and experiencing the problems in living with obesity resulted in a Devalued Self-concept and the developing of Trade-Off Processes. Reaching the Point of Critical Tolerance is the next stage in the career of obesity. The Point of Critical Tolerance is the time in the career process when some significant event occurs which alters or threatens the balance or adjustments that had been achieved in the five core areas and which would indicate commitment to a new identity. At this point the support system for the balance deteriorates. This deterioration occurs in the core area of greatest sensitivity for the individual when some

thing happens to invalidate the logic or rationalization of the balance or trading. Review of the data indicates that all of the subjects reached a Point of Critical Tolerance at some time in their Career. For example, the data revealed that regardless of their wives' efforts to improve appearance, some husbands were ashamed of the size of their wives. One respondent had designed and made a dark-colored dress with flattering lines so that she could be attractive when going with her husband to his company's party. When she came into the living room as they were leaving for the party, he remarked, "I didn't realize you had gotten so fat." She felt crushed and resolved to rid herself of this weight. Other examples of Reaching the Point of Critical Tolerance for some of the respondents were boyfriends threatening rejection without weight loss and teasing from peers. One respondent's weight had climbed so much that when she went to purchase clothes for her daughter's wedding she could not get into a size 24½ dress. She left the store feeling defeated as she could find nothing that was appealing to her. Purchasing desired clothes had become so traumatic or impossible that she vowed to begin weight reduction.

Weight Controlling

Trade-Off Processes fail to maintain a constructive equilibrium due to the occurrence of a critical incident. (Reaching the Point of Critical Tolerance) The individual views his array of options and finds that his Trade-Off Processes alone will no longer counter the devalued self-concept. He must do something more definitive. Therefore, he seeks an avenue of Weight Controlling. This is not to say the Trade-Off Processes are not used in conjunction with Weight Controlling, but attempting to decrease body size in order to improve self-concept and reduce the effect of the Point of Critical Tolerance is paramount for the individual during this stage. Some of the respondents developed their own reduction regimes without medical help and others worked with health professionals. Some of the weight reduction methods that were tried by the sample were eight hundred - one thousand calorie diets with or without appetite suppressants, a diet with a rigorous exercise program, Stillman's Quick-Weight Loss, and Weight Watchers.

To illustrate the conceptual model as reflected in the data, the example of Miss J. will be utilized. Miss J. began her career of obesity at the age of sixteen. At this age she recalled being teased by her peers and being told that she needed to lose weight by her

family doctor (Identification of Obesity-self and other). Miss J. remembered having to begin purchasing her clothes at special stores that carried large sizes or having to make them herself as she could no longer purchase clothes in an ordinary store. Her social life was curtailed as she had very few dates while her friends were dating frequently.

At the time of the interview, Miss J. (age twenty-two years, weight, 195 pounds), was still making her own clothes or buying them at stores that carried large sizes. She was dating sporadically but felt that her weight prevented men from being attracted to her. Miss J. noticed that she tired more rapidly than her peers when riding a bicycle or hiking and had thus begun to reduce these social activities because of her embarrassment. This young woman was experiencing a Devaluation in Self-concept as she had grown to detest her body, especially "the rolls and wrinkles of fat." She felt different from her peers and felt unwanted by men. "I wish I could like myself, but living with this weight always reminds me that I'm different, unattractive." Miss J. began using caftans more often to hide her fat. She experimented with make-up techniques to enhance her positive attributes and wore solid colors rather than prints to decrease accentuation of her large size. (Trade-Off Processes)

Miss J. described her greatest problems as loneliness and wanting to date like other young women her age. She met a young man during

a party at a friend's house. Miss J. was thrilled by the fact that he asked her to go out with him. The following week they went to a dance, but Miss J. felt uncomfortable as she thought people were looking at her and snickering because of her weight. She overheard a woman say, "How could he date her; she's so big!" To reinforce the problem, the young man did not ask her out again. Miss J. felt so miserable and lonely that she became determined to lose weight. (Reaching the Point of Critical Tolerance). Thus, in combination with the Trade-Off Processes mentioned previously, Miss J. began to control her weight by taking the chorionic gonadotrophin injections and remaining on a five hundred calorie diet. (Weight Controlling)

This respondent had experienced each of the stages of the career process as illustrated in the conceptual model, and her life as described at the time of the interview further illustrated the intertwining nature of the process: identity of obesity and living with the social and physical properties of this condition which affect activities of daily living and self-concept. The increasing problems resulting from corpulence continued to lower self-concept and reinforced the obese identity. This led to the development of Trade-Off Processes and, eventually, to reaching the Point of Critical Tolerance when something else had to be done: finding

a means of Weight Controlling. Trade-Off Processes had made living with obesity more tolerable for a period, and the self-concept had improved a bit. However, Reaching the Point of Critical Tolerance had dealt a severe blow to Miss J.'s self-concept and shattered the temporary balance achieved through Trade-Off Processes. As Miss J. began to lose weight she felt better about herself and had begun to feel attractive: improved self-concept. She began to wear more stylish clothes, and people were telling her how good she looked. In time, her obese identity may be a thing of the past.

In addition to the universal qualities of the career process as illustrated in the example above and in the diagram of the career model, the researcher began to raise questions as to the possibility of a variety of contingent careers. Within the universal career of obesity can contingent careers be formulated around age, sex, economic status, and marital status? For example, the sample had many problems in common, but what made an area such as health or social life relatively low in importance to one individual and quite significant to another? The scope of the study did not lend itself to exploring the variety of contingent careers that might be generated from the universal career of obesity, but rather sought to develop and purport a theory of obesity as career.

In summary, the conceptual model, Obesity as a Career, illustrates the entrance and progress of an individual through a process closely intertwined with self-identity and normal life activities. Movement through the various stages is evidenced through the obese individual's experiencing problems related to obesity in a variety of areas of his life. These experiences in living with obesity result in changes in self-concept and increased problems in various activities of daily living leading to actions such as developing Trade-Off Processes and beginning Methods of Weight Controlling. Each stage is interrelated and important in supporting the life of the process. A portion or all of this career process may last for a life time or may end when a person changes his identity through weight loss, and, thus, makes his exit from the career of obesity. The implications of the use of this career model for health professionals and others will be presented in the following chapter.

PART III - THE DESSERT

Chapter VI - Implications for Health Care

One realization to be gleaned from this research is the complexity of this prevalent problem, obesity. Corpulence carries with it psycho-social, physiological, and cultural components that serve to complicate both its process and subsequent treatment. As demonstrated through data illustration and summation, each obese person is an individual with obesity acting and interacting to various degrees within different areas of his life. As a result of this research, a similarity in terms of process was discovered among obese individuals. This similarity of process is represented by the Career Model described in the preceding section. A remaining dimension of this dissertation is to determine in what manner this model might be utilized by health professionals in their work with obese clients. The Career Model serves as a framework from which health professionals can develop the necessary tools to assist corpulent individuals. The purpose of this chapter is 1) to suggest

ways in which the health professional may utilize components of this career process in assessing and planning for obese individuals and 2) to suggest areas for further research.

Utilization of Career Model for Health Care Planning

A. Assessment

The initial encounter with a client is very important. It is at this time that the identification of obesity can be made by the health professional through use of observation, communication, and physical examination. The first meeting is crucial for setting the climate for the health-caring relationship. The obese person, as with any client, is deserving of an individualized assessment free from the stereotypes often assigned to corpulent people and conducive to the respect of personal right. This thorough, individualized assessment will form the basis for determining a client's problems and subsequent health care planning (Yura and Walsh, 1973). The term, assessment, is defined as "the act of reviewing a situation for the purpose of diagnosing a client's prob-

lems. So that the health professional can judge which actions are necessary to assist the client with his problems, he or she uses their skills of perception, observation, and communication." (Yura and Walsh, 1973, p.23)

Assessment is an ongoing process, not an action taken only at the time of the initial client-professional encounter. With obese individuals as with all clients, an ongoing assessment must occur in order to determine changes, to detect further problems, and to evaluate the situation.

An in-depth health history is paramount in developing a thorough assessment. Utilizing the Career Model as a framework for obtaining a health history, the health professional can ascertain the reason the client is seeking health care and if the client perceives himself to be overweight. Obtaining this data can serve as a basis for guiding the remaining history and health care planning. Clarifying these issues permits the health professional to begin from a common reference point with the client. For example, determining the reason the person has sought health care might reveal the problematic nature of the increased weight for the individual and his readiness for weight controlling. Has he come to seek help for his increased weight or for another health problem? A person's perceiving him or herself as overweight gives a clue to their realization of an obese identity or weight problem.

Other areas to be explored during the initial assessment include: 1) How does the increased weight affect the obese individual's life? 2) How long has he lived with obesity and what has it been like for him to live with his corpulence? 3) What feelings does the obese individual have about himself? 4) Of his weight related problems, which is the most difficult? In what ways does he deal with his weight related problems to make them and his weight more tolerable?, i.e., "trade-offs?" 5) What, if anything, does the individual want to do about his weight? If weight reduction, what ideas might he have for weight controlling?

Questions such as those illustrated above, can further the health professional's understanding of an individual's experiences with obesity. One can determine if the individual perceives himself as overweight and any devaluation in self-concept that may have occurred. An assessment of this nature can also assist the health professional in determining problems that an individual may be experiencing because of his weight and any Trade-Off Processes he might be utilizing to cope with his weight related problems. A very crucial area that can be determined through this type of questioning is the readiness of the obese person for Weight Controlling: (Reaching the Point of Critical Tolerance) Without reaching this stage, the corpulent person is still maintaining a balance through

Trade-Off Processes in order to protect his self-concept. Therefore, it is important to determine the stages of the career process experienced by the obese individual and the stage he is in at the time of the client-professional encounter.

A professional is now ready to plan a more realistic, individualized health care plan as well as to predict problems and possible experiences for the client. For example, if, through assessment, an obese client is found to be in the stage of utilizing Trade-Off Processes and has not experienced the Point of Critical Tolerance his readiness for Weight Controlling is questionable. The client is still maintaining his state of equilibrium; utilizing the Career Model the health professional may be able to predict that in time the Trade-Off Processes will probably fail to maintain a constructive equilibrium and the person will experience a critical incident. By knowing the greatest problem areas for the client, which areas are most destructive for the self-concept, the health professional may also be able to predict the nature of the critical incident: a social related incident, health related incident, etc. The professional's readiness to give support in predicted areas is increased as well as his ability to possibly move the individual toward weight reduction.

B. Intervention

After assessing the obese client in the manner described above, the health professional can begin to develop a health care plan with the client. The two primary roles for intervention by the health professional are 1) supportive and 2) educational. Dividing these roles may at times be an artificial separation of actions as in actual practice they often cannot be separated. However, after the health professional has assessed the readiness of the client he can know what avenue to pursue. For example, the client who has not recognized or accepted the fact that she is overweight may become more resistant and angry if she is pushed toward weight controlling. One must start with where the client is to assist the individual in making decisions and coping with weight within the framework of his life style. It is conceivable that an individual may move through weight controlling to normal weight and then revert back into obesity. Health professionals must develop interventions to understand how to assist individuals to achieve acceptable weight if they desire to do so.

The supportive role consists of listening to the client and providing time for discussion of any problems related to obesity. The health professional attempts to reinforce the client's strengths and rebuild the devalued self-concept or prevent further damage in

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this area. The obese person is assisted in developing constructive trade-off mechanisms for coping with the weight related problems he has identified. He finds himself accepted and recognized for his individuality.

The educational role is more action oriented. As mentioned above, these strategies may be done in conjunction with support, and certainly reinforcement and support are necessary for every aspect of the health care plan. The educational role may be more prominent after the Point of Critical Tolerance has been reached. The readiness of the learner is a key factor in his educational process (Hilgard, 1956). Therefore, the obese person's readiness is paramount for his receptivity of weight related education and subsequent action.

This role consists of providing necessary nutritional and exercise instructions and assisting the individual to recognize his eating patterns as well as utilizing knowledge of the client as an individual to attempt to mobilize him toward weight reduction. After the Point of Critical Tolerance has been reached the client has experienced a crucial incident to provide momentum and the health professional can use this occurrence to reinforce weight controlling.

Working toward weight reduction, changes in eating behavior, etc., may be trying for both health professionals and obese individuals. Patience and understanding to foster a collaborative effort

are necessary. Weight Controlling and developing Trade-Off Processes are ~~not~~ mutually exclusive parameters. If a person wishes to lose weight, he might be engaged in a means of Weight Controlling and utilizing Trade-Off Processes to deal with problems resulting from obesity simultaneously. For example, one member of the sample was on an eight hundred calorie diet, but was also making her clothes in order to have attractive attire and was experimenting with various types of make-up to enhance her positive attributes. There are no magic answers or quick solutions for weight problems. Much effort is demanded of the obese individual and much support and guidance needed by health professionals.

The Career Model developed through this research can serve as a guideline for health professionals in assessing the obese client and developing a health care plan. Rather than offering a solution for obesity this model has instead offered a framework for viewing corpulence. Health professionals often present a curative attitude and are frustrated when seeing such health care risks like obesity and not being able to anything about them.

Before working with obese individuals, the health professional might contemplate a conflictful issue. If the obese client does not choose to lose weight and is maintaining a constructive equilibrium, what action does the health professional take? Does he support individuals in their decisions and assist them in maintaining constructive Trade-Off Processes? Does the health professional, knowing the health risks of obesity, attempt to precipitate the Point of Critical Tolerance

or some means of Weight Controlling? Perhaps the answer lies with the person experiencing such a health-related problem. Perhaps such an individual should assume more responsibility for his health care and have a choice in determining his health status. The health professional has the responsibility of informing a person of his health risks and assisting the individual in seeing alternative actions, but the choice lies ultimately with the affected client. To borrow an old cliché, "You can lead a horse to water, but you cannot make him drink."

Generalizability of Conceptual Model

The research findings demonstrate the use of the Career Model in the health care of the obese individual. In addition, the findings suggest the feasibility of applying this concept to other chronic conditions characterized by problems of self-concept, adaptive behaviors, and strategies of management. Any chronic health problem involving those components of the Career Model may involve a sequential process similar to the problem of obesity. A health professional,

therefore, may be able to utilize this conceptual model in the assessment and the subsequent health plan for persons experiencing a problem of chronicity. The findings of this research suggest the implications of further research in the application of the Career Model to other problems of chronicity where the client himself is a critical factor in the ongoing management of his health problem.

Implications for Further Research

As mentioned earlier, the researcher began to raise questions as to the possibility of a variety of contingent careers within the universal career of obesity: contingent careers formulated around age, sex, economic status, and marital status. The subjects had many problems in common, but what made an area such as health or social life relatively low in importance to one individual and quite significant to another? Possibly the age of the individual might be of greater influence when talking about health and obesity: older individuals may place a higher priority on health; the young may be more concerned with appearance. For the most part a common theme among the sample was that obesity affected the respondents' feelings

about themselves and limited them in some way, whether it was the inability to buy clothes, or the inability to be physically active. Also, would a man express the same types of problems? Where might he place greater significance? For four of the respondents, weight affected their job opportunities. These respondents had educations of high school or below and belonged to a lower socio-economic bracket. Would a person of a lower economic status place a higher priority on obesity limiting their job opportunities while someone in a higher income bracket place priority on difficulty purchasing pretty clothes? A further area for consideration is that of the Point of Critical Tolerance. Do all obese individuals reach a Point of Critical Tolerance at some time(s) in their lives? Is desired success in weight reduction necessarily related to the reaching of a Point of Critical Tolerance, and, if so, how and by whom might this point be precipitated at an early state in the weight climb?

Should one attempt to precipitate the Point of Critical Tolerance? If so, what would be the consequences of such action? In what way(s) could the Point of Critical Tolerance be precipitated? The questions raised here as well as others that might arise through a critique of this research offer a number of avenues for exciting and important research through exploring various contingent careers in obesity and the utilization of this conceptual model with other chronic health problems as well.

In summary, the research has resulted in a framework that can further the understanding of obesity and provide a basis for working with obese individuals. The multi-faceted aspects of corpulence as well as the individuality of its complex nature have been demonstrated. Hopefully, a consciousness has been raised as the need for further research in obesity is great, particularly around the questions raised in the preceding section.

Health professionals have often shared in the condemning cultural attitude of society as related to obesity (Bruch, 1973). Many physicians' attitudes toward the obese patient have been less than constructive. They have described obese individuals as weak-willed, ugly, and awkward (Maddox and Lieberman, 1968). This research, presented from the obese individual's perspective can broaden not only the understanding, but also the approaches to health care utilized by health professionals. "Prevention of obesity calls for social acceptance of human diversity and fostering freedom and initiative in the individual. It repudiates manufactured, stereotyped ways of life and demands instead respect for human individuality" (Bruch, 1973, p. 387).

No man is free who is a slave
to his body.

- Seneca

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APPENDIX A

Interview Schedule

Interview Schedule

Introduction:

As you know, I am doing research in the area of obesity. I would like to talk with you about what it's like for you to be overweight; how it affects your life from day to day. Perhaps with this information I can help other obese individuals in the future. First, I would like to ask you a few specific questions, and then we can move into a discussion of your experiences as an overweight person.

1. Age?
2. Sex?
3. Height? Weight?
4. Marital Status? How long have you been married? Do you have any children? Where are they?
5. Occupation? If retired, how long? Why did you retire?
6. Spouse's occupation? Average yearly income of family?
7. Education?
8. Any other members of family have weight problem? If so, who and for how long?

I. First Awareness of Being Overweight

- A. Time first discovered being overweight.
- B. Being a fat person in family.
- C. Experiences with being "teased" about weight.
- D. Family's thoughts about being overweight vs. the individual's thoughts.
- E. Being fat in school.
- F. Overweight affecting dating and other social activity.

II. Struggling with Obesity

- A. Determination whether struggle has (had) occurred.
- B. Experiences in coping with obesity - When? Strategies?
- C. Process (accounts) of successes and failures.
- D. Most costly consequence of trying to lose weight?
- E. Means of weight reduction attempted. Treatments (or other attempts) that have been helpful.
- F. Reason(s) for beginning weight reduction regime.

III. Living with Obesity

- A. Being an overweight person.
- B. Prices one pays to remain fat.
- C. Difficulties experienced because of weight - mobility, clothes, social life, feelings about self, employment, health.

- D. Rank difficulties in order of priority.
- E. Coping with difficulties resulting from weight.
- F. Advantages of being overweight; accepting it?
- G. Individual's desire to lose weight. Desired weight.
- H. Possible effect(s) of weight reduction on life of individual.
- I. The person you would want to look like is _____.

Dissertation Summary

Title: Obesity as A Career

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Abstract:

This exploratory study focuses on obesity from the obese individual's perspective and describes how self-identified obesity determines, modifies, or impedes normal human processes such as dressing, relating with others, moving about, working, and caring for health needs. The sample of twenty women, ranging in weight from forty to two hundred and fifty pounds in excess of normal weight, was interviewed and observed in their homes. These obese individuals were selected from the following facilities: comprehensive medical clinics, obesity clinics, health spas, and private physicians offices. The information sought included: the meaning of obesity to the individual, how obesity affected everyday activities, eg., dress, family and social life, occupation, health, how individuals coped with their obesity, the difficulties experienced because of increased weight.

As a result of this research, a similarity in terms of process was discovered among obese individuals: the process of Obesity as a Career. The data generated the definition of "career" as a course of events around some identity (obesity) which, when abstracted, constitutes a pattern of some piece or all of a person's life. Stages of the Career Process are: Identification of Obesity, Devaluation of Self-Concept, Trade-Off Processes, Reaching a Point of Critical Tolerance, Weight Controlling. The conceptual model, Obesity as a

Career, illustrates the entrance and progress of an individual through a process closely intertwined with self-identity and normal life activities. Movement through the various stages is evidenced through the obese individual's experiencing problems related to obesity in a variety of areas of his life. These experiences in living with obesity result in changes in self-concept and increased problems in various activities of daily living leading to actions such as developing Trade-Off Processes and beginning Methods of Weight Controlling. Each stage is interrelated and important in supporting the life of the process. A portion or all of this career process may last for a life time or may end when a person changes his identity through weight loss, and thus, makes his exit from the career of obesity. The implications of the use of this career model for health professionals working with obese individuals is also described.